Understanding suicidality in adults with learning disabilities: A qualitative exploration of the experiences and perceptions of professionals in NHS Community Learning Disability Services

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"With the realisation of one's own potential and self-confidence in one's ability, one can build a better world." – Dalai Lama

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Abstract

Background: Experiences of suicidality within the learning disability population remain largely unknown. Despite suicide prevention strategies being a standard part of clinical practice in all healthcare settings in the United Kingdom (UK), no research has been conducted exploring professionals' understanding of suicidality as it presents in clinical practice. Difficulties with communication and comprehending death make navigating suicidality in this population more complicated. Little is known about clinicians' experience of engaging with individuals with learning disability who presents with suicidality.

Aim: The current research aimed to explore professionals' experiences and perceptions of suicidality as it presents for individuals with a learning disability in clinical practice.

Method: A qualitative methodological approach was applied using Reflexive Thematic Analysis. Semi-structured interviews were conducted with 14 professionals working in an NHS Community Learning Disability Service.

Findings: Two overarching themes, five main themes, and four sub-themes were generated. The findings highlight that although suicidality was not seen as the most frequent presentation, it was consistently described as one of the most complex and challenging to navigate. Professionals understood suicidality to be grounded in the multitude of adversities, particularly trauma, social exclusion and unmet relational needs. It was predominantly viewed as a form of communication and learned relational strategy, which professionals interpreted as a desire for connection rather than a direct intention to die by suicide. Professionals highlighted the challenges of determining risk and needing to navigate uncertainty around the comprehension of death and suicide within this population. Emotional and professional burdens were evident, with professionals describing the weight of caring, concerns about responsibility, and the strain of working within current system limitations.

Conclusion: The findings are considered in the context of existing research and psychological theory, with an overview of the study's strengths and limitations provided. Clinical implications and future research are also considered.

Chapter One: Introduction

Chapter overview

This chapter provides an overview of the key concepts of this thesis. An exploration of the idea of suicidality and the historical trends that exist about this phenomenon, as well as any relevant theories of suicide, will be presented. The chapter will also consider current and historical understandings of Learning Disabilities (LD) within the societal and cultural perspectives of the United Kingdom (UK), which have evolved significantly over time. Following on from this, an overview of the policies related to suicide prevention efforts in healthcare will be presented. It will then explore what is known about suicidality within the context of the LD population, presenting findings that provide a background and rationale for this study.

Understanding the concept of Suicide and Suicidality

The Socio-Political and Historical Context of Suicide

The term "suicide" originates from the Latin word *suicidere*, combining *sui* ("I") and cedere ("to kill"), which was eventually adopted into the English language as "suicide," meaning "to kill oneself" (Volant, 2005, as cited in Maloku & Maloku, 2020). The concept of suicide has a long and extensive social history, with perspectives and discourse having shifted dramatically across cultures (Stacy & Schulkin, 2023). The concept of suicide has featured in many early writings and mythologies, where it has been portrayed as both a tragedy and a noble or heroic act intertwined with themes of honour, celebration and resistance (Stacy & Schulkin, 2023). Historical figures, including Cleopatra, Mark Antony, and Lucretia of Rome, chose death to preserve their dignity or protect against injustice and humiliation (Chitwood, 1986; Drogula, 2019, as cited in Stacy & Schulkin, 2023). Some of these narratives have positioned suicide as an act of love, romanticising the idea of dying for love, while in others, suicide was a process by which someone secured their legacy and power in society (Stacy & Schulkin, 2023). Additionally, the idea of dying to preserve honour after a military defeat has been observed regularly throughout history. In Japan, the ritual of *seppuku* (or *hara-kiri*) allowed a samurai to die by disembowelment to protect dignity and the family's honour (Pierre, 2015, as cited in Stacy & Schulkin, 2023). Similarly, Stoic philosophers, such as Seneca, Musonius, and Cato, regarded virtue as the sole intrinsic good, arguing that suicide was generally unreasonable but could be justified when used to uphold integrity or escape tyranny, pain or humiliation (Falkowski, 2016, as cited in Stacy & Schulkin, 2023).

In contrast, religious orders, specifically those in monotheistic faiths such as Judaism, Christianity, and Islam, largely condemned suicide (Barry, 1995; Gearing & Alonzo, 2018, as cited in Stacy & Schulkin, 2023). In particular, the Christian Church viewed suicide as a mortal sin thought to result in eternal damnation. Suicide was viewed to be a violation of the commandment "Thou shalt not kill", which proclaimed that life, as a divine gift, should not be rejected (Torgler & Schaltegger, 2012). This stance shaped medieval punishments of suicidal acts, which included denial of burial rights, desecration of the body, and seizure of property, often further punishing and disgracing the families of anyone who died by suicide (Torgler & Schaltegger, 2012; Neeleman, 1996, as cited in Stacy & Schulkin, 2023). Due to the dominance of Christian rulings in England, these perspectives and practices were pertinent throughout the history of the UK, where the term "felo de se", Latin for "felon of oneself", was often used, implying criminal guilt (Seabourne & Seabourne, 2001).

Throughout the Enlightenment period, philosophers such as David Hume and d'Holbach challenged these strict religious views, arguing that suicide could be a morally justifiable expression of autonomy, particularly in the face of unbearable suffering (Frey, 1999; Hume, 1777). With an increasing emphasis on secularism and autonomy, suicide came to be reframed as a personal decision rather than a religious or criminal offence, where it was considered rational and even honourable in certain situations (Beauchamp, 1989; d'Holbach, 1770; Hume, 1777, as cited in Stacy & Schulkin, 2023).

In the 19th century, Darwin's theory and Nietzsche's existentialism further shifted the discourse surrounding suicide. Nietzsche highlighted the importance of finding meaning in life and creating a sense of purpose, viewing suicide as a personal decision to be approached with dignity and free from divine judgement (Nietzsche, 1964). Simultaneously, the rise of psychiatry positioned suicidality as a symptom of psychological disorder and mental illness rather than moral failure. However, the stigma and legal implications remained, where suicide attempts were still met with legal consequences up until 1882 in the UK. In 1823, the practice of desecrating the bodies of individuals who died by suicide was ceased, followed by a policy ending the seizing of their assets outlined in the Forfeiture Act (1870). Although there were calls for the decriminalisation of suicide earlier, reform was not evident until the 20th century with the establishment of the Suicide Act (1961), which outlined that suicide was no longer punishable as a crime. This Act, which remains in effect today, marked an important shift across legal and social attitudes, from moral sin to prevention and care, though assisting another to die by suicide remains illegal. The use of the term 'committed suicide' continues to be discouraged, with expressions like 'died by suicide' being the preferred term (Beaton et al., 2013), which is thought to be less stigmatising and more encouraging of people to seek support (Freedenthal, 2017).

The presenting history provides important insights into suicide and the associated stigma that has existed throughout history. The shifts in perspectives highlight its susceptibility as a construct to cultural, social, and political influences, which provide a context within which suicide can be understood in depth. Today, suicide is known to be one of the leading causes of death worldwide (WHO, 2021), with more than 700,000 people dying by suicide each year (WHO, 2021). As a global health issue, the implementation of suicide prevention strategies and policies has become a standardised and pivotal part of providing healthcare, aimed at reducing and preventing deaths by suicide where possible.

Suicide prevention strategies and policies in the UK

In the UK, efforts to support and prevent suicide commenced with the founding of The Samaritans by Chad Varah in London in 1953. This service aimed to provide confidential emotional support for those experiencing suicidal thoughts and intentions. However, the implementation of more structured policies did not emerge until the publication of the National Service Framework for Mental Health (Department of Health, 1999) by the UK government in 1999, which reflected the gradual move towards the decriminalisation of suicide. This framework aimed to increase access to services for individuals with mental health difficulties, while also preventing or anticipating crises where possible. This was followed by England's first 'Suicide Prevention Strategy' in 2002, aimed at reducing the overall rate of suicide, through the promotion of a more coordinated, systematic and multi-agency approach to suicide. Updates in suicide prevention strategy guidelines in 2012, 2017 and 2023 reinforced the goals towards decreasing deaths by suicide with a specific focus being placed on suicide in high-risk groups, improving data monitoring, and promoting mental wellbeing, as well as supporting those who are bereaved by suicide (Department of Health, NHS, 2012, 2017, 2023). Simultaneously, the Five-Year Forward View for Mental Health (2016) and the NHS Long-Term Plan (NHS England, 2019) outlined the longer-term plans for healthcare settings to embed further efforts to prevent suicide through crisis services and integrated support across primary care settings. In 2025, NHS England updated the national prevention strategy titled *Staying Safe from Suicide*, which aims to instil change in how suicide prevention is approached within health care services (NHS England, 2025). This guide was developed in response to longstanding concerns regarding the effectiveness of traditional risk stratification models, categorising individuals into "low," "medium," or “high” risk. Research has shown that a significant proportion of individuals who died by suicide while under mental health services were previously assessed as “low risk” (NHS England, 2025), indicating a need for reform. The new guide prioritised relational and contextual understanding over standardised tick-box risk assessments. It emphasised the importance of understanding individuals’ unique circumstances and identifying the factors contributing to their suicidal distress. The guideline recognises the fluctuating nature of suicidal ideation and outlines the importance of person-centred approaches and collaborative safety planning. It advocates for the use of appropriate, non-stigmatising language that fosters compassionate, empathetic communication when working with risk (NHS England, 2025).

Contemporary definitions of Suicidality and Self-Harm

The National Institute for Health and Care Excellence (NICE) provides a broad understanding of suicidal and self-harming behaviours, referring to it as “*intentional self-poisoning or injury, irrespective of the apparent purpose”* (NICE, 2022) and includes behaviours both with and without suicidal intent. The American Psychological Association (APA) dictionary defines suicidality as *“the risk of suicide, usually indicated by suicidal ideation or intent, especially as evident in the presence of a well-elaborated suicidal plan”* (APA, n.d), while other professional bodies and organisations, such as the British Psychological Society (BPS), provide a much more specific understanding of suicidal behaviour, outlining it as *“thoughts and behaviours related to suicide and self-harm that do not have a fatal outcome. These thoughts include the more specific outcomes of suicidal ideation (an individual having thoughts about intentionally taking their own life); suicide plan (the formulation of a specific action by a person to end their own life) and suicide attempt (engagement in a potentially self-injurious behaviour in which there is at least some intention of dying as a result of the behaviour)”* (BPS, 2017 p. 1). Across the literature, definitions of the concept also vary, for example, in one paper self-injurious behaviours were considered as any deliberate infliction of harm to oneself without intent to die (Simeon & Hollander, 2001) while another defined suicidal behaviour as "*potentially self-injurious behaviour with a non-fatal outcome, for which there is evidence that the person intended to kill him/herself*" (O' Carroll et al., 1996 p. 247).

These variations reflect the confusion that exists around defining suicidality, which can present challenges towards addressing it in clinical practice and conducting research in the field. It also reflects the differing opinions surrounding whether self-harming presentations should be included with suicidality. Self-harm is frequently characterised as the deliberate act of inflicting harm on oneself, with non-suicidal self-injury (NSSI) being distinguished by the absence of intent to die, setting it apart from suicidal behaviour, which involves a desire to end one's life (Maddox et al., 2017). Nevertheless, self-harm is a strong predictor of suicide, and many of the approaches used to prevent and manage them both are similar. This emphasises that although they could be viewed as distinct entities, they are inherently intertwined (Knipe et al., 2022). Nonetheless, defining self-harming and suicide behaviours, particularly in the context of specific populations, like autism or LD, which is further complicated by the high prevalence of self-injurious behaviours that are often present, that may not be associated with suicide intent (Lovell, 2008). Furthermore, presenting behaviours in these conditions are often classified and interpreted differently, reflecting the broad variation in abilities that are encompassed within the diagnosis, which may impact how the behaviour is treated. For example, symptoms of trauma are frequently concealed behind behavioural presentations of anger or self-injurious behaviours for individuals with LD (Truesdale et al., 2019) and therefore may not be recognised. It has also previously been found that symptoms that individuals with a mild LD presented with were considered consistent with a personality disorder, but a similar presentation in those with a more profound LD was not considered to be linked to a personality disorder and instead classified as ‘problem behaviour’ (Deb et al., 2001; Alexander & Cooray, 2003; Gentile et al., 2022). This conflicting approach to how behaviours are classified and understood in LD populations further complicates the process of understanding and defining concepts like suicidality in this population. For the purpose of this thesis and given the uncertainty around self-harm and how it might be interpreted, this thesis defines suicidality as any behaviour that could be linked to suicide, including intentional self-harm.

Theoretical understandings of suicidality

While the causes of suicide are not always clear, it is widely accepted that suicidality results from an intersection of a multitude of factors (O’Connor & Nock, 2014). Several psychological and theoretical perspectives have been developed to understand the phenomenon better and determine the potential reasons why suicide may occur, which will be outlined below.

Psychodynamic and early developmental understandings of suicide.

Psychodynamic perspectives on suicide incorporate the work of Freud. Though not dedicated solely to suicide, his writings provide clear thinking around death and suicide through concepts of melancholic depression and unconscious conflict (Briggs, 2006). In Mourning and Melancholia (1917), Freud introduced the idea that suicide could be understood as an unconscious expression of internalised aggression (Rönningstam, Weinberg & Maltsberger, 2008), with suicidal impulses arising from internal conflicts between love and hate where death wishes are turned inward, as a form of self-punishment, or revenge against a disappointing or rejecting object who has caused harm or shame (Briggs, 2006). Expanding on this, Menninger (1938) identified three unconscious motives underpinning suicide: the wish to kill (revenge), the wish to be killed (guilt/punishment), and the wish to die (escape). He understood suicide as an extreme representation of the death instinct and an imbalance between life and death drives.

Psychanalyst Melanie Klein, in her object relations theory, links suicidal experiences to early relationships with primary caregivers. She argued that unmet needs or trauma in these relationships shape the internal world, potentially leading to guilt, self-hatred and despair. Klein identified two key developmental stages: the *paranoid-schizoid* position, where the caregiver is split into 'good' and 'bad' parts, and the *depressive* position, where both parts are integrated and viewed as not solely one or the other but a combination of the two. Failure to reach the depressive position can result in internalised anger or despair, contributing to suicidal intentions (Klein, 1935, 1946). In the paper '*Understanding the psychodynamics of the pathway to suicide'* (Gibbons, 2024), a psychological pathway to suicide is presented (Campbell & Hale, 2017; Maltzberger & Buie, 1980, as cited in Gibbons, 2024). It outlines the unconscious processes that may underlie suicidal thoughts and behaviours, understanding individuals to move through stages from 'pre-suicidal vulnerability' to 'pre-suicidal' before arriving at a stage of engaging in the 'suicide act', with each stage being prompted by a 'triggering event' (Campbell & Hale, 2017; Gibbons, 2024). The frame posits that those who die by suicide often perceive it as the only viable escape from intense physical and psychological distress that they are unable to process or make sense of through symbolic processing (Gibbons, 2024). This difficulty in processing may be linked to biological or temperamental predispositions, insufficient nurturing in the early years or the experience of a loss that exceeds the person's capacity to manage, thereby increasing the death drive (Gibbons, 2024; Levi et al., 2008). This pathway considers these vulnerabilities as explanations for higher rates of suicide noted in certain groups of people, including men and individuals with autism spectrum disorder (Cassidy & Rodgers, 2017; Gibbons, 2024). The pathway emphasises that difficulties in processing distress may result in 'splitting', which can create a 'state of ambivalence' towards suicide; wanting to end the pain but simultaneously wanting to live (Gibbons, 2024). Suicidality in this state can present as confusing, where risk fluctuates between the two states. The pathway states the importance of understanding which 'suicidal state' is present to determine the inherent risk present (Gibbons, 2024; Campbell & Hale, 2017; Maltzberger & Buie, 1980).

Attachment theory also provides a framework for understanding suicidality, linking it to early relational experiences, which are considered to influence future emotional security and relationship behaviours. Bowlby (1973) suggested that consistent, responsive care fosters secure internal models of the self as worthy and others as dependable. In contrast, inconsistent or rejecting care may lead to internal beliefs that others are unreliable and the self is unlovable. These internal working models, shaped by repeated early interactions, influence how individuals respond to stress and form relationships later in life. Building on Bowlby's work, Ainsworth et al. (1978) identified two forms of insecure attachment: anxious, characterised by heightened distress and difficulty calming, and avoidant, where children suppress their distress and exhibit emotional detachment upon reunion (Bretherton, 1992). This was later extended, with attachment styles categorised into: secure, preoccupied, dismissing, or fearful (Bartholomew & Horowitz, 1991).

Adams (1994), in a developmental model, frames suicide as an extreme form of attachment behaviour, used to express intense distress and anger toward an inconsistent or absent attachment figure. According to this model, individuals with anxious or avoidant attachment styles may struggle to access relational support during times of crisis, unlike those with secure attachments. As a result, they may be more likely to turn to suicidal thoughts or actions. Additionally, individuals with insecure attachments tend to be more sensitive to relational threats, such as loss, rejection, or disappointment, which increases the likelihood that they may seek care from others in the absence of alternative strategies and activation of their attachment system (Green et al., 2021). A growing body of research has supported this theoretical perspective connecting insecure attachment styles with suicide ideation and attempts (Lessard & Moretti, 1998; Grunebaum et al., 2010), which has been demonstrated in clinical and non-clinical samples in adolescents (Adams, 1996; Sheftall et al., 2014) and adults (Palitsky et al., 2013). Though the link between attachment difficulties and suicide for individuals with LD has not been directly explored, individuals with LD are considered to exhibit high rates of insecure and disorganised attachment styles (Fletcher, 2016; Hamadi & Fletcher, 2019; Bateman et al., 2023), which could contribute to experiences of suicidality.

Psychodynamic and attachment theories provided significant contributions towards understanding the psychological complexities of suicidal presentations, through their focus on unconscious drives, internalised aggression, and attachment difficulties in early life. Nevertheless, there exists a challenge in researching certain concepts of these theoretical perspectives due to their complexity and largely unobservable nature, resulting in a more limited empirical evidence base underpinning the theories (Schechter et al., 2022). However, understanding an individual's internal processes and attachment style can help uncover their motives underpinning suicidal presentation (Yakeley & Burbridge-james, 2018), which are invaluable when considering formulations of suicide presentations.

Sociological framework.

Emile Durkheim's influential work, Suicide (1897, as cited in Durkheim, 2005), introduced a sociological framework for understanding suicide. His work highlighted the impact of social factors and structure on suicide and challenged purely individualistic or moral views towards suicide. His theory posits that suicide is a social issue that centres on the degree of social integration (Gerardi, 2020), claiming that the more socially integrated a person is, with strong social connections and a sense of belonging, the less inclined they will be to commit suicide (Bearman, 1991; Durkheim, 1951, as cited in Durkheim, 2005). Within this frame, the high levels of social exclusion and systemic disadvantage (Goodley, 2017) that feature heavily in the history of LD, which will be explored later in this chapter, give rise to the potential link to experiences of suicidality for individuals with LD.

This model identified four distinct types of suicide based on the interplay between social integration and social regulation: egoistic, anomic, altruistic and fatalistic suicide. Egoistic suicide arises from a lack of social integration, fostering a deep sense of disconnection from society, while also suggesting that society may also be disconnected from the individual (Ritzer, 2011). Those who experience this form of suicide often consider themselves to be outcasts or outsiders and may struggle to find their place within social groups. Anomic suicide refers to suicide resulting from the distress an individual experiences due to the absence of societal constraints which would otherwise provide structure and guidance (Durkheim, 1951). This type of suicide typically arises during periods of extreme stress, disruption or instability, including significant political transformations (Ritzer, 2011) or economic changes (Moore, 2017), where typical societal structures are disrupted. According to Durkheim, fatalistic suicide arises when an individual experiences minimal social integration yet faces extreme regulation by societal norms and rules (Durkheim, 1951; Abrutyn & Mueller, 2014). This type of suicide is driven by excessive regulation that restricts an individual’s freedom and autonomy (Gerardi, 2020). Alternatively, altruistic suicides describe suicide that occurs from experiences of excessive integration within a social group (Ritzer, 2011), primarily placing a higher value on the needs of the group, with their own needs becoming secondary. According to Durkheim, this type of suicide might present in the form of dying for a cause, tradition or self-sacrifice (Durkheim, 1951).

In essence, Durkheim’s theory aligns with the idea that suicidal presentations are not solely a result of personal circumstances and are deeply influenced by cultural norms, social expectations, and structural conditions (Bowring, 2016). Although it provides a valuable framework that may explain variations in suicide trends across societies and cultures, the model has been argued to be overly simplistic in its explanation of suicide, ignoring the interplay of societal and individual factors (Ritzer, 2011).

Diathesis-Stress Model of Suicide.

This model, also referred to as stress-vulnerability models, conceptualises difficulties as a product of an interaction between an individual's predisposition towards experiencing a difficulty and the stressor (Ingram & Luxtin, 2005; Zuckerman, 1999). Original models have predominantly focused on biological vulnerabilities, such as genetics, but contemporary versions also consider social and cognitive factors that may contribute to increased susceptibility to a range of difficulties (Ingram & Luxtin, 2005; van Heeringen, 2012). Stress, which is widely recognised as a determinant of general psychopathology, is thought to stem from significant life events (e.g., bereavement, job loss) or the accumulation of minor stressors. According to the model, distress emerges when stress levels exceed an individual's coping capacity, particularly in those with higher vulnerability (Monroe & Hadjiyannakis, 2002). Significantly, it accounts for variations in responses and capacity for distress, acknowledging that those with greater predisposition who encounter a seemingly minor stress may experience more distress in comparison to those with lower vulnerability (van Heeringen, 2012).

A variety of stress-vulnerability models specific to suicidal behaviour have been put forward. Schotte and Clum (1982) presented a stress/problem-solving model of suicide, noting poor problem solving under high stress environments could result in increased risk of suicidal presentation, alongside increased hopelessness and depression. Mann and Arango (1992) considered suicide through the integration of neurobiology and psychopathology, with suicidal risk being associated with alterations in serotonin levels. Williams and Pollock (2001) propose a cognitive stress-diathesis model for suicidality, which they refer to as a "cry of pain" model. The model conceptualises suicidal behaviour as a response to situations that evoke a person's sensitivity towards signals of defeat, perceived ‘no escape’ and perceived ‘no rescue’. Behaviours may escalate when attentional bias towards stimuli that trigger defeat responses is combined with limited problem-solving, solutions and hope. A clinical version of the model was put forward, viewing suicidal risk to be influenced by a diathesis, and not solely the disorder (Mann et al., 1999). For example, in comparing those who attempted suicide versus those who did not across a clinical sample exhibiting suicidal ideations, those who did were found to exhibit higher rates of aggression, impulsivity, comorbid personal disorder diagnoses, substance use, family history of suicide and childhood abuse, indicating that suicidal risk is not only determined by the disorder but also by other factors that may increase the likelihood of experiencing increased suicidal thoughts and behaviours. The biopsychosocial model’s explanation of the interaction of various factors that contribute to suicidal behaviours makes it a widely used and practical frame to understand presentations of suicide, though no research has directly examined this model within the context LD populations.

Interpersonal Theory of Suicide.

The interpersonal theory of suicide posits that individuals “die by suicide because they can and because they want to” (Van Orden et al., 2010, p. 583). A key contribution of this model is its distinction between suicidal ideation and suicide attempt, offering insight into why not all individuals experiencing suicidal thoughts act on them (Ribeiro, & Joiner, 2009; Chu et al., 2018). The model considers suicidal ideation to be driven by two core factors, thwarted belongingness and perceived burdensomeness. Thwarted belongingness refers to an unmet need for social connection and belonging (Baumeister & Leary, 1995), while perceived burdensomeness is a belief that one is a burden and that their death would be of more value than life (Chu et al, 2018). However, while the theory understands that the two factors can elicit active suicidal desire, that alone is not sufficient for suicide to occur, and a person is thought to have to develop the capacity for suicide, which involves overcoming the natural instinct towards self-preservation (Joiner, 2005). The acquired capability, which increases suicidal risk, is thought to emerge through repeated exposure to painful experiences that increase tolerance towards pain and reduce fear of dying. Serious suicidal attempts are understood to present when hopelessness about both perceived burdensomeness and thwarted belongingness co-occur with suicidal capability (Chu et al., 2018). As such, the model offers a comprehensive framework for understanding why some individuals transition from ideation to action. Nevertheless, despite its strengths, the model's empirical support is mixed. A review by Chu et al. (2018) identified gaps in the literature and questioned its generalisability, particularly to populations such as military personnel. Similarly, a study by Moseley et al. (2022) found partial support for the model in individuals with ASD, with the study indicating support for the aspects of perceived burdensomeness and suicidal capability, but the role of thwarted belongingness was less clear. These findings suggest the model may need adaptation for specific groups and highlight the need for further research, including with individuals with LD.

Understanding the Concept of 'Learning Disability'

Defining 'Learning Disability'

Currently, LD is understood to be a developmental condition characterised by limitations in intellectual functioning (e.g, reasoning, problem-solving, and learning) and adaptive behaviour (social and daily living skills). IQ scores below 70, along with difficulties in adaptive functioning, typically indicate intellectual disability, which is classified as mild, moderate, severe, or profound. The DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition; APA, 2022) and the ICD-11 (International Classification of Diseases, 11th Revision; WHO, 2019) outline that the diagnosis of LD also requires evidence of developmental onset before age 18, alongside having a significant impact on daily life, which is also advised by NICE guidance (NICE, 2016).

Intellectual functioning is typically assessed through culturally appropriate standardised psychometric tests, with the fourth edition of the Wechsler Adult Intelligence Scale (WAIS-IV) being the most commonly used test in the UK. Although such tests provide helpful insights into specific areas of difficulty, their use has been debated in the literature due to the significant variance in the meaning of "intelligence" across cultures, alongside their narrow scope and potentially biased outcomes, where the reliance on intelligence as a measure for defining LD is not always appropriate (Siegel, 1989). These criticisms prompted the recent updates in the DSM-5 and ICD-11, which reflect the general shift towards a more comprehensive understanding of LD and the need for broader, less limiting assessments to consider a diagnosis of LD.

The Socio-Political History and Development of 'Learning Disability' in the UK

Until recently, the history of LD was intertwined with psychiatry, special education, and general disability (Jarrett & Tilley, 2022; Tilley et al., 2021). However, movements towards generating a more 'inclusive history' have been established to reflect and highlight the distinctive historical journey and context underpinning LD. Similar to the concept of suicide outlined above, narratives surrounding LD have shifted dramatically over time in response to the ever-changing societal and cultural attitudes that have existed, which are known to have significantly influenced how the LD population has been understood, treated, and supported throughout history (Goodey, 2011; Malli et al., 2018). The Social History of Learning Disability Research Group (SHLD, 2023) at the Open University has led efforts to support individuals with LD in documenting their unique history, producing a timeline that traces the evolving discourses and policies regarding LD, which has been used to guide this section.

In ancient Greece and Rome, LD was believed to originate from divine intervention from God, or punishment, with individuals with LD viewed as inferior, which often led them to be excluded and marginalised (Goldberg & Lippman, 1974; Langdon Down Museum of Learning Disability, n.d). Early Christian charity prompted some kindness and care, though LD was still widely viewed as sinful or possessed by demons (Langdon Down Museum of Learning Disability, n.d) and shunned or hidden from society. They were often referred to as "natural fools" or "lunatics" and little distinctions were made between LD and mental illness, with both groups being placed together in workhouses, prisons or asylums, including privately run "mad houses" as utilised by wealthier families (Mauger & Smith, 2021).

The Lunacy and County Asylums Acts, introduced in 1845, facilitated access to care from public asylums, which were also accessible to those from lower socio-economic backgrounds (PoUK; Parliament of the United Kingdom, 1845). However, the Idiots Act (1886) was the first legal step towards recognising people with LD as distinct and advocated for specialist care, education, and training, though they continued to be treated under existing systems (Burrell & Trip, 2011), where terms like "idiots" and "imbeciles" featured in the language used when referring to them.

The early to mid-20th century marked a shift towards more scientific and medicalised views of disability, heavily influenced by the eugenics movement, which promoted controlling the reproduction of those deemed 'unfit' through 'good breeding' (Atkinson, 2003; Burrell & Trip, 2011). While the influence of eugenicist views waned over time, particularly following World War II, they played a significant role in shaping mental health and social policies in Britain at that time. The Mental Deficiency Act (1913), informed by the 1908 report of the Royal Commission on the Care and Control of the Feeble-Minded, legalised the segregation and institutionalisation of individuals with LD in 'colonies' generated explicitly for the "mentally defective", who were considered a threat to society

(SHLD, n.d; Hall, 2008). Furthermore, Alfred Tredgold's *Mental Deficiency* (1908) textbook became foundational to the training of doctors and nurses, which continued to endorse prevailing attitudes towards LD that encouraged segregation and the prevention of deficiency through sterilisation (Hall, 2008).

The introduction of the Disabled Persons Act in 1944 was one of the first legal measures aimed at promoting inclusivity and reducing discrimination against people with disabilities in the workplace, marking a considerable shift in perspectives for individuals with LD. In 1946, the National Association of Parents of Backwards Children (NAPBC) was also founded by parents advocating for better support and education provisions. The establishment of the National Health Service (NHS) in 1948 further solidified the shift by granting people with LD free healthcare, although institutionalism remained common practice. The deinstitutionalisation of LD care began to emerge in the 1960s and 1970s, leading to the closure of large hospitals. Furthermore, the establishment of the Mental Health Act (1959), which revoked the Mental Deficiency Act (1913), promoted voluntary admissions where possible. The changes signified a broader shift in perceptions of LD, reflected in the rebranding of the NAPBC to The Royal Mencap Society (commonly known as Mencap) due to the term 'backwards children'. However, terminology like "mental subnormality" seen in legislation persisted, highlighting ongoing societal stigma and inferiority (Mental Health Act, 1959; Atkinson, 2003).

The work of Jack Tizard, a pioneering psychologist in the 1950s and 1960s, significantly influenced the move from institutionalisation towards community-based care for people with LD in the UK. His 'Brooklands Experiment' (1954; Lyle, 1960; Tizard, 1960) demonstrated significant improvements, such as social skills, independence and emotional wellbeing for children relocated to small residential settings compared to those who remained in institutions. The findings were foundational for policies like the 1971 White Paper, "Better

Services for the Mentally Handicapped”, and the Community Care Act 1990, aimed at reducing institutional care and promoting person-centred care, increased inclusion and integration into society (Raynes, 1977; NHS & CCA, 1990).

In the 1980s, inspired by self-advocacy movements worldwide, the UK’s first ‘People First’ group was formed to promote autonomy while challenging continued discrimination experienced by people with LD. These groups laid the groundwork for greater involvement of people with LD in policymaking and service design. They advocated for terms such as ‘People with Learning Disability’ to replace outdated and derogatory labels, with ‘learning disabilities’ being formally adopted by the government in the late 1990s and early 2000s as the preferred term in policy and NHS services (SHLD, n.d). Though ‘intellectual disability’ is more commonly used in academia, the term' learning disability' is used throughout the write up of this thesis to reflect the terminology used within UK healthcare settings, with both terms referring to the same population. The use of ‘learning disability’ ensures consistency with UK clinical language and aligns with the terms used by the professionals who participated in this study.

The change in terms was reflected in the 2001 White Paper, ‘Valuing People,’ and the Equality Act (2010), both of which aimed to further embed the promotion of rights, independence, dignity, and inclusion, alongside involvement and protection against discrimination for individuals with a disability. These advancements reflect the significant shift in perceptions and understanding of LD, marking the progression made towards reducing stigma and acknowledging the potential of individuals with LD reflected in the improved care and treatment of people with LD, including increased integration and independent living (SHLD, n.d; Mencap, 2023).

Nevertheless, despite this progress, individuals with LD continued to face significant barriers, including healthcare inequalities, prevailing stigma and neglect. Mencap's *'Death by Indifference'* (2007) report highlighted serious failures in the NHS care that led to avoidable deaths of individuals with LD, exposing continued institutional neglect. The report prompted the Department of Health, *'Healthcare for All'* (2008) inquiry, which confirmed systemic issues in the care of individuals with LD. Subsequent reports, including Mencap's "*Death by Indifference: 74 Deaths and Counting*" (2012) and the uncovering of systematic abuse of individuals with LD at the Winterbourne View Hospital by staff in 2011, highlighted continued failings. These findings led to serious case reviews and the establishment of the 'Transforming Care' programme (2012-2015), aiming to reduce institutional placements. However, by 2018, a large proportion of individuals with LD remained detained in such settings and were often subjected to restraint and seclusion practices (Mencap, 2023). The 'Out of Sight' report (2020) highlighted the continued mistreatment of individuals with LD, emphasising the need for further systemic reform and improved care and services for those with LD.

Despite the history of LD indicating an apparent lack of understanding around the potential needs of this population, current guidelines emphasise the importance of services recognising, identifying and responding to the subjective needs of the individual in a person-centred way (NICE, 2018). In addition to the Valuing People strategy (DOH, 2001), trauma-informed approaches are increasingly being integrated into LD services in recognition of the high rates of trauma that individuals with LD are often exposed to, which centre on the principles of safety, trustworthiness, choice, collaboration, and empowerment (Fallot & Harris, 2001). The framework outlines the need for services to recognise and understand signs of trauma in individuals with LD and respond in ways that reduce its impact (Keesler, 2014). Furthermore, professionals in LD services are also expected to recognise the mental health needs of individuals with LD and assess for any potential risk, including suicide risk, that may exist in line with the latest national suicide prevention strategy (NHS, 2025).

As noted in the timeline above, the attitudes that organisations and services hold about individuals with LD, as well as how presentations, including suicidality, are perceived, can have a significant impact on an individual's experience of care (Malli et al., 2018; Atkinson, 2003). Therefore, exploring professionals' understanding and perception of suicidality in the LD population is essential to ensure they access appropriate treatment and are responded to in a compassionate, informed way that aligns with best practice in suicide prevention.

Suicidality in Learning Disability Populations

Current knowledge about suicidality in learning disability populations: What do we know?

Historically, it has been suggested that individuals with LD are at a reduced risk of suicide due to the nature of their cognitive and emotional challenges (Dodd et al., 2016), as well as ongoing questions about their ability to fully comprehend the concept of death and dying (McEvoy, 1989; Dodd et al., 2016). Although the view that individuals with LD are entirely incapable of understanding death has been widely contested, the extent and nature of their understanding remains a subject of continued debate (McEvoy, 1989; McEvoy et al., 2002). This uncertainty appears to mirror a similar debate regarding experiences of suicide within this population, and although no research has been presented to support the idea that having an LD protects against suicidality (Smiley, 2005; Bellman, 2021), the ambiguity remains surrounding individuals with LDs' ability to comprehend death and, therefore, suicide.

Experiences of suicidality, as defined earlier in this chapter, are typically understood in terms of an individual's clear intent or motive to die, which in turn presumes a certain level of understanding and awareness of death/dying (Shneidman, 1977). Unsurprisingly, based on this, individuals with LD were previously considered not to be at risk of experiencing suicidality. Nevertheless, despite the query regarding limited understandings of death, several papers have indicated that suicide and suicide related behaviours, including suicide attempt can and do occur in this population (Dodd et al., 2016; Chan & Bhandarkar, 2025), though the prevalence of this remains undetermined due to a significant lack of quality data (Dodd et al., 2016; Chan & Bhandarkar, 2025). Nonetheless, some papers have suggested that suicide rates amongst individuals with LD are comparable to those without LD (Merrick et al., 2005), while others have argued that they are lower (Hurley et al., 2003). In addition, findings from the NHS and King's College LeDeR Report (Learning from Lives and Deaths: People with learning disability and autistic people, 2022) indicate that suicide is reported much less often as a cause of death for individuals with an LD. While this may support the claim that individuals with LD are less at risk of dying by suicide, it has been argued that this could reflect the broader issue regarding underreporting and lack of recognition of experiences of suicide amongst this population (Dodd et al., 2016; Chan & Bhandarkar, 2024), reflecting the frequently cited problem of diagnostic overshadowing across the LD population (Mason & Scior, 2020). Subsequently, it has also been posited that deaths by suicide for individuals with LD, may also be frequently classified as accidental or undetermined, which may not provide an accurate representation of the overall rates of suicide across the LD population (Patja et al., 2001; Patja, 2004; Dodd et al., 2016; Chan & Bhandarkar, 2024). Research has highlighted that suicidal behaviour and attempts are more common in those with milder impairments (Dodd et al., 2016; Chan & Bhandarkar, 2024), but it has also been reported that they are present in individuals with moderate to severe impairments too (Menolascino et al., 1989; Walters et al., 1995), albeit this is considered to be at a lower rate (Dodd et al., 2016). These findings suggest that the level of LD could be considered a potential risk factor for experiences of suicidality, with mild LD being associated with increased risk (Dodd et al., 2016; Chan & Bhandarkar, 2024). However, given the possible underestimation of rates of suicide in this population, this remains inconclusive. Furthermore, most of the research that has been conducted is predominantly based on individuals with mild LD, which may account for the higher rates noted in this proportion of the LD population (Dodd et al., 2016). Additionally, difficulties with communication and the ability to articulate or express, which have been considered to be linked to the issue of underreporting (Chan & Bhandarkar, 2024), may also reflect the lower rate noted in those with more severe impairments.

Reviewing the two systematic reviews conducted by Dodd et al. (2016) and Chan and Bhandarkar (2024), which explored the nature of suicidality in individuals with LD, several other risk factors for suicidality in this population, in addition to the level of LD, have been identified. These include the presence of co-morbid mental disorder loneliness, lower income status, social isolation, and deceased family or social support as well as experiences of trauma, domestic violence and an individual's gender and age (Hand et al., 2020; Merrick et al., 2006; Ludi et al., 2012; Huntington & Bender, 1993; Eaton et al., 2021; Cervante et al., 2023; Hurley, 2002; Luiselli et al., 2008; Patja et al., 2001; Peleggi et al., 2021; Walters et al., 1995). Other studies reported a history of self-harm and previous suicide attempts to be associated with increased risk (Lunsky et al., 2012) alongside co-morbid physical health or medical difficulties (Benson, 1988). Furthermore, a study investigating the link between suicidality in LD and autism found that those with a dual diagnosis of LD and autism appeared to be at much lower risk of experiencing suicidal ideation but were in fact at higher risk of attempting suicide when compared to those with a diagnosis of LD (Hand et al., 2020). However, another study by Carvantes et al. (2023) found increased rates of suicidal ideation amongst individuals with LD and autism.

Many of these risk factors are unsurprising given the broader literature on suicidality, which has consistently found that experiences of adverse childhood experiences (ACEs) and maltreatment, including a history of child abuse and neglect, are associated with increased risk of suicidal behaviours (Thompson et al., 2019). It has been well documented that a significant proportion of individuals with LD have experienced various forms of adversity and abuse, including historical systematic abuse (Heslop et al., 2014), which may increase an individual's vulnerability to mental health difficulties and potential suicidality. Similarly, mental health difficulties, including depression and personality disorder, alongside low income or lack of employment, and a history of self-harm have all been established as some of the most significant risk factors associated with suicide and suicide attempts (Orsolini et al., 2020; Blakely et al., 2003; Borges et al., 2010; Windfuhr & Kapur., 2011; McCllelland, Cleare & O'Connor, 2023), which are commonly present amongst the LD population (Smiley, 2005; Cooper et al., 2007; Richards et al., 2001). This indicates that individuals with LD exhibit many of the risk factors that have been linked with suicidal thoughts and/or behaviours in other populations, and given this, it remains unclear why suicide rates are potentially reported as lower compared to non-LD populations. Furthermore, increased rates of suicide have been noted in individuals with autism, where challenges with executive functioning, elevated cognitive abilities, and limited capacity for emotional regulation were all found to be associated risk factors, alongside mental health comorbidities, social isolation, interpersonal difficulties and a cumulation of life stressors (Brown et al., 2024).

Difficulties around communication have consistently been highlighted as a key challenge in supporting individuals with LD, including around death, dying and bereavement (Lord et al., 2017; Tuffrey-Wijne & McEnhill, 2008), and it seems plausible that similar difficulties may prevail about suicidality. Self-report disclosures and asking about suicide are commonly relied upon to explore suicidal risk in clinical populations, as per the suicide prevention guides (NHS, 2025), which may be problematic in LD populations. Individuals with LD can have widely differing capacities for receiving, understanding, and expressing their experiences through language. Individuals with LD often rely on those around them to recognise and interpret a language composed of behaviours and signs that can be highly individualised. Research has highlighted that how people with LD express distress is often idiosyncratic in nature, with meaning typically being apparent only to those who know the individual well (McKenzie, Smith & Purcell, 2012). This may present a significant challenge in identifying suicidality or its indicators within this population, with risks related to suicide potentially being reliant upon others to recognise and understand. However, significant criticisms in relation to the current research on suicidality in LD populations are outlined in two systematic reviews, highlighting that many of the studies conducted in this area are of low quality, relying on retrospective data, predominantly from case studies (Dodd et al., 2016; Chan & Bhandarkar, 2024). Furthermore, minimal research is available involving professionals' understandings and perspectives of suicidality in LD populations, including their experiences around navigating suicidality in clinical practice, despite suicide risk assessments being a standard and imperative part of supporting individuals with LD towards accessing appropriate treatment and intervention (NICE, 2016; NHS, 2025), which this study hopes to address.

Working with suicidality in learning disability populations.

Significant challenges have been noted to exist for those providing support to individuals with LD regarding death/dying in general, with both carers and staff having been found to frequently misunderstand responses to death and level of understanding when working with individuals with LD (Dodd et al., 2005; McEvoy & Smith, 2005; Dowling et al., 2006; MacHale et al., 2009; McEvoy et al., 2010). Considering suicidality within the context of the LD population, it seems plausible that a similar challenge may persist regarding suicide. A study by Wark et al. (2018) in Australia explored support workers' perceptions of suicide in individuals with LD through an online survey. The findings revealed a notable lack of systemic risk assessments within LD organisations, despite 77% of respondents reporting prior experience supporting individuals with LD who exhibited suicidal behaviours, and 76% having worked with individuals who had explicitly expressed a desire to end their own life. The study also highlighted a prevalent belief that individuals with LD lack the cognitive capacity to plan a suicide attempt, often resulting in their categorisation as low risk. These results support the idea that suicidality is not an uncommon phenomenon within this population. However, it may also indicate that experiences of suicide are regularly dismissed, which may impact whether they gain access to appropriate treatment and intervention. Furthermore, a qualitative study, which is the only known one to be published, exploring suicidal behaviours of individuals with LD or autism from the perspectives of the individual and support staff was conducted in Canada (Persechino, Morin & Bardon, 2024). Three emergent themes, '*Ability-Demand Inequality, Significant Negative Life Events,* and *Chronic Helplessness* were identified and found to be linked to experiences of suicidality by both groups of participants (Persechino et al., 2024). These themes included experiences related to high pressure or demand that exceeded the individual's perceived ability, a general sense of feeling like they have little control over their lives, and a wealth of difficult life events, particularly transitions. In addition to these, some staff identified that they felt suicidal behaviours were utilised "to gain advantages, avoid unwanted tasks, or otherwise change their environment" as well as "increase services" and "attention" (Persechino et al., 2024). Moreover, the study highlighted that individuals with LD or autism exhibited a broad range of suicidal behaviours, often involving planning and lethal methods, contrary to assumptions about limited understanding and capacity noted previously. While some staff in the study were confident that individuals in this population could comprehend suicide, others were unsure and reported having never had a conversation about suicide with individuals with LD or autism. Consequently, since staff often serve as the primary conduit through which individuals with LD or autism access services, any misunderstandings or gaps in their awareness of their clients' suicidal behaviours or comprehension of death and suicide could hinder recognition and generate a barrier to individuals accessing appropriate support (Persechino et al., 2024). It is therefore imperative that professionals' perspectives regarding suicidality are explored, which could potentially have a significant impact on the experience of care for individuals with LD accessing services. Additionally, other studies have emphasised that recognising and addressing the needs of professionals working in services is crucial for effectively reducing suicidal behaviour (Awenat, 2017), with stress and burnout being frequently reported by those in caring professions, including NHS staff (Johnson et al., 2017; Wilkinson, 2015; Iacobucci, 2021) that could have significant impacts on care provided to individuals accessing such services.

Rationale for the current study

Despite risk assessments being an integral part of health services in the UK, where recognising potential risks of suicide is paramount (NHS, 2025), no research has been conducted to explore the perceptions and experiences of professionals working with individuals with suicidality within the context of LD services which this study aims to address. This study aims to explore the perceptions and understandings of clinicians working in LD services concerning their experiences of suicidality for people with LD. It hopes to expand the current knowledge base and deepen understandings of suicide related thoughts and behaviours and their associated risk factors as they occur within this population. More explicitly, it is anticipated that the study will provide insight into current clinical practices and the experiences of staff in assessing and managing suicidal risks for this population.

The research aims to address the following questions:

- How do professionals working in LD services understand suicidality experiences in the LD population/How does suicidality present in this population?
- What are some of the risk factors associated with experiences of suicidality as it presents in NHS Community Services for individuals with LD?
- How is suicidal risk assessed and managed in this population, and what are the challenges, if any, to conducting such assessments?
- What is the experience of professionals working with suicidality in clinical practice?

Chapter Two: Literature Search

Chapter Overview

This chapter aims to provide a comprehensive review of the broader literature surrounding the objectives of the current study. As outlined in the preceding chapter, the rationale for the current study was provided in advance of conducting a literature review, due to the lack of qualitative empirical research surrounding professionals' experiences of working with individuals with LD who present with suicidality. Consequently, there were insufficient studies to conduct a qualitative systematic literature review of this specific topic. Nonetheless, a review was conducted to explore the experiences of various professionals working with suicidality in non-LD community healthcare settings in the UK, where the results were used to inform the current research and compare the findings.

Introduction

Conducting a systematic literature search is a crucial component of academic research, providing a strong foundation upon which the expansion of knowledge can occur (Snyder, 2019). Through the examination of previous work in a particular topic area (Cooper et al., 2018), gaps within the literature can be identified (Xiao & Watson, 2019), and a future direction of research can be established (Fink, 2019). In the following section, a review of the literature will be presented addressing the question: How do professionals working in community-based health care settings in the UK experience working with suicidality and suicide related risk in clinical practice?

Method and Search Strategy

A systematic search was conducted to identify literature relevant to the review using a modified version of the PICO format (Population, Interest, Context; PICo) to fit a qualitative methodology appropriately (Butler, Hall & Copnell, 2016). The search strategy used was developed following the recommendations outlined by Bettany-Saltikov (2012) and Aromataris and Riitan (2014) as presented by Bulter et al. (2016). This strategy provides a systematic approach to searching each database, aiming to minimise the researcher's influence on the search outcome (Bulter et al., 2016). The current review was also conducted and reported in line with Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009).

Four electronic databases, CINAHL Complete, Medline with full text, PsycINFO, and PsycARTICLES (via EBSCO Host) were used in the literature search. Only papers published from 2002 were included in the review, following the implementation of suicide prevention strategies for healthcare settings in the UK. The geographical location parameter was used to restrict the analysis to studies conducted in the UK. The healthcare systems in other countries, such as the US, are notably different in their structure and funding, and therefore may not accurately represent the experiences of the intended participants in the current research project.

An initial search was conducted between September 2022 and December 2022, followed by a second search in December 2024. A review paper (Fedorowicz et al., 2023) exploring how suicide risk is assessed in healthcare settings in the UK was identified during the follow-up search, identifying two potential studies to include. While the paper covers a related topic, the current literature review differs in several ways. Fedorowicz et al. (2023) explored how suicide risk assessments are carried out and experienced by healthcare professionals, patients, and carers or family members, with patient perspectives making up 85.51% of participants across the 18 included studies. In contrast, the present review focuses exclusively on the perspectives of professionals, aligning more closely with the research question. Furthermore, the 2023 review incorporated both qualitative and quantitative studies from a variety of settings, including hospitals and community environments. The current review, however, concentrates explicitly on community-based professionals, excluding hospital or inpatient contexts to better reflect the intended setting of this study. Additionally, unlike the narrative approach used by Fedorowicz et al. (2023) to map the scope of the literature, this review employs a thematic synthesis to identify recurring themes and patterns, aiming to generate a deeper understanding of the topic.

Search terms were kept quite broad to ensure all relevant papers were included. The search terms and keywords used are presented in Table 1.

Table 1:

Electronic Database Search Terms

PICo	Search Terms
Population (P)	“staff*” OR “support worker*” OR “care worker*” OR “professional*” OR “team member*” OR “Nurs*” OR “Occupational*” OR “Speech*” OR “physio*” OR “multidisciplinary*” OR “MDT” OR “Physician*” OR “Doctor” OR “psychiatrist” OR “Practic*” OR “Psychologist” OR “counsell*” OR “social worker” OR “healthcare assistant”
	AND
Interest (I)	"Suicidality" OR "Suicidal Ideation" OR "Suicide" OR "Suicidal Thoughts" OR “Suicidal Behaviour” OR “Suicidal attempt” OR "Suicid*" OR “Suicide risk” OR “suicide risk assessment” OR “screening for suicide”
	AND
Context (Co)	“Community healthcare settings" OR "Community health services" OR "Community*” OR "Outpatient*” OR “Secondary*” OR “Primary*” OR “Mental*” OR “Social*” OR “Social care”
	AND
Method	“qualitative research" OR "qualitative method*" OR "interview*" OR "focus group*" OR "ethnographic" OR "phenomenolog*" OR "action research" OR "Thematic analysis" OR "Content analysis" OR “Grounded*” "experience" OR "understanding" OR "Perception" OR "attitude" OR "knowledge”

Inclusion and Exclusion Criteria

Papers were selected for review based on the criteria presented in Table 2.

Table 2

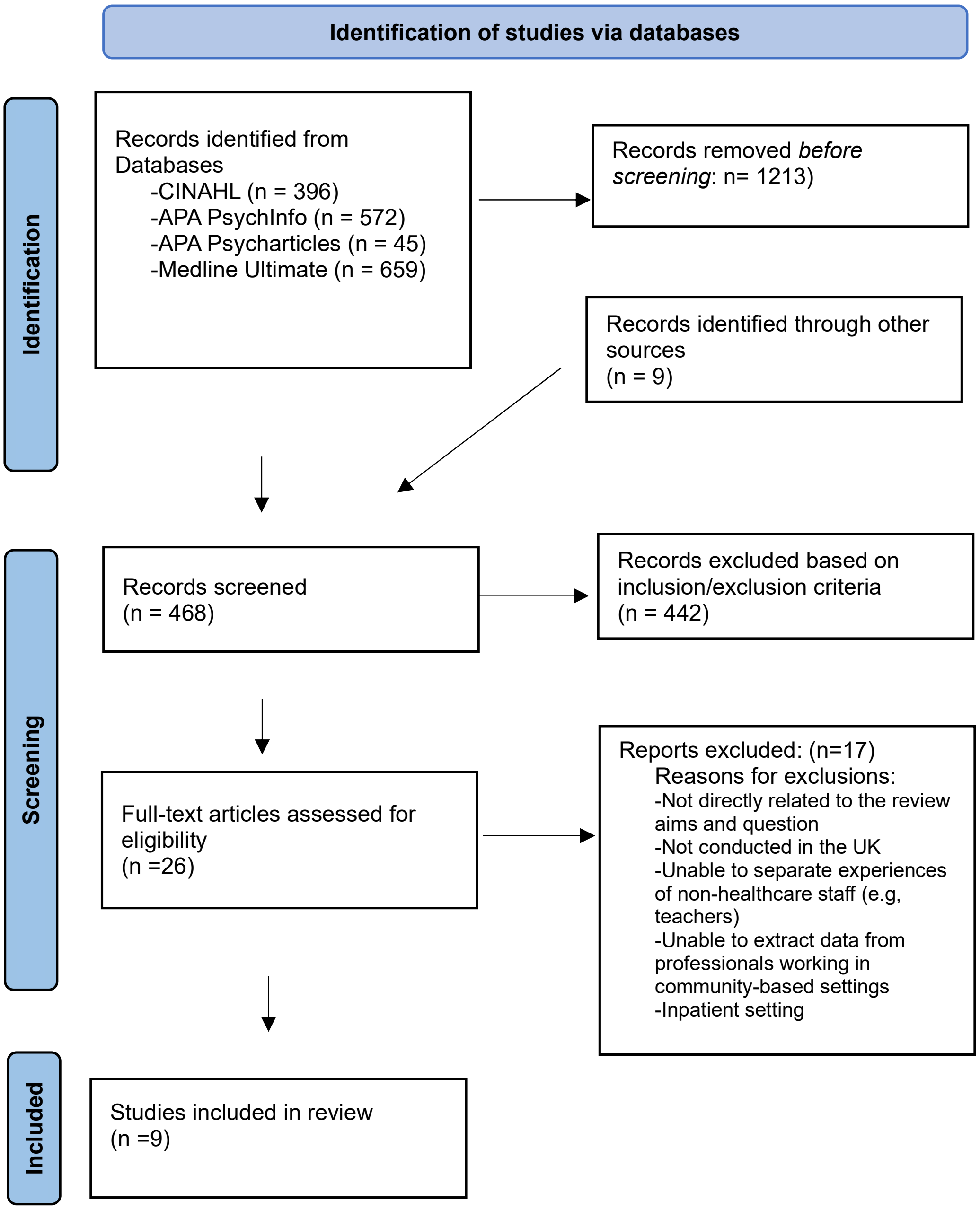
Outline of inclusion and exclusion criteria

	Inclusion and exclusion criteria
1.	Only studies utilising qualitative methodology were included in the review to gain an in-depth understanding of the experiences of professionals around managing suicidality in clinical practice, which quantitative studies may not capture.
2.	In any study using a mixed-methods design, only the qualitative responses were extracted.
3.	Studies focusing on the staff's own experience of suicidality or assisted suicide were not included.
4.	Research focusing on the experience of losing someone through suicide or on other risk concerns, such as violence/aggression or self-neglect, was also excluded from the review.
5.	Only papers that viewed self-harm in the context of suicidality were included. Non-suicidal self-injury-related papers were excluded.
6.	Studies conducted in inpatient/hospital-based settings were excluded. However, studies that used a mixture of settings, including both inpatient and community, were included if the data from community-based staff could be extracted.
7.	Only papers that were peer-reviewed and written in English were included.

All papers that were initially selected were then screened based on their title, abstract, or full text. Any articles not meeting the inclusion or exclusion criteria were carefully considered against the research question and aim of the review. Forward and backwards citation chaining was also employed on the identified articles to identify any relevant papers that may have been missed (see Figure 1 for an outline of the screening process).

Figure 1

Systematic Literature Review Flow Chart



Data Synthesis

There has been much development in the range of methods used to synthesise qualitative research (Dixon-Woods et al., 2005; Barbour & Barbour, 2003), including thematic synthesis and meta-ethnography. While both are frequently used, meta-ethnography is particularly helpful in producing theories used to explain phenomena of interest (Britten et al., 2002), which is not the aim of this review. Consequently, thematic synthesis was selected due to its transparency and accessibility, alongside its suitability for aggregating qualitative findings across diverse studies and its utility in presenting practice-relevant insights (Thomas & Harden, 2008), which aligns with the focus of the current review.

The synthesis was conducted following the three-step approach outlined by Thomas and Harden (2008). The first stage involved line-by-line coding, which was applied to all extracted text labelled as 'results' or 'findings' in the original papers, including verbatim quotations of participants. The next stage involved developing descriptive themes from the initial codes, while the third and final stage entailed generating analytical themes. This final stage involved a process of interpretation that extends beyond the original data, resulting in a deeper understanding of the findings through the generation of new explanations or constructs (Thomas & Harden, 2008).

Results

Search results and study characteristics

Study characteristics were extracted using pre-determined categories (See Appendix A for summary table). Five of the studies used semi-structured interviews (Saini, Chantler & Kapur, 2016; Chandler, King, Burton, & Platt, 2015; Reid, Edge, Pratt, & Wittkowski, 2024; Briggs, Slater & Bowley, 2017; Leddie, Fox & Simmonds, 2021) and two used a combination of surveys and semi-structured interviews (Fox, Stallard & Cooney, 2015; Saini et al., 2010).

One used a focus group and semi-structured interviews (Michail & Tait, 2016), and the final study used a survey-only design (Bajaj, Borreoni, & Ghosh et al., 2008).

Thematic analysis (TA) was the most common method of analysis used by four studies (Fox et al., 2015; Briggs et al., 2017; Reid et al., 2024; Saini et al., 2016), while three used a thematic framework analysis (Saini et al., 2010; Bajaj et al., 2008; Michail & Tait, 2016). The final two utilised an IPA analysis (Leddie et al., 2021) and a narrative TA approach (Chandler et al., 2015).

The sample size varied considerably across the studies, ranging from 10 to 159. Six of the studies were conducted in the context of a Primary Care setting/GP surgery (Fox et al., 2015; Saini et al., 2016; Saini et al., 2010; Bajaj et al., 2008; Michail & Tait, 2016; Chandler et al., 2015). Two studies were conducted in NHS Community Child and Adolescent Mental Health (CAMHS) services (Briggs et al., 2017; Leddie et al., 2021) and one in NHS Specialist Perinatal Mental Health services (Reid et al., 2024). Participants included GPs (N = 389), psychologists (N=5), psychiatrist (N= 6), social worker (N=1), nurses (N =16), nursery nurse (N=1), family therapist (N=1), trainee psychiatrist (N=1), service/team manager (N=2) and occupational therapist (N=2).

Quality Appraisal

Although there is some debate surrounding the application of quality assessments in qualitative reviews, conducting a quality assessment provides a way to evaluate the contribution of each paper to the overall synthesis (Stenfors et al., 2020). A methodological quality assessment of the studies included in the current review was conducted using the Critical Appraisal Skills Programme (CASP) tool (Public Health Resource, 2013; CASP, 2008). Each paper was reviewed and rated against the 10 CASP questions, using the guidance outlined by Long at al. (2020), with the aim of evaluating the quality, validity, and relevance of the papers objectively according to 10 criteria. See Appendix B for a summary of CASP quality appraisal.

Each of the studies included in the review was deemed to have good methodological quality. They all had clear objectives and aims for the study and utilised an appropriate qualitative design to address their research aims. Most studies employed semi-structured interviews or focus groups as a method of data collection, with two studies employing a mixed-methods design using a cross-sectional survey alongside interviews to collect data (Fox et al., 2015; Saini et al., 2010). Another study utilised a survey to explore GPs' experiences of suicidality and semi-structured interviews to explore patients' experiences (Bajaj et al., 2008), with only the survey responses being included in the current review. Researchers in this mixed-methods study utilised a survey design to gather professionals' perspectives, aiming to increase response rates by minimising the time required for participants to complete the study. However, this design limited the depth of information and experience as compared to the other studies and the experiences provided by participants within the study. Nevertheless, each of the studies was found to provide value in terms of their research and contributed to the overall themes generated.

The inclusion and exclusion criteria across most of the studies were well-defined and appropriate to the research aims. Some of the studies opted for minimal exclusion and inclusion criteria, including all professionals interested and available to participate from particular settings or practices and included perspectives of professionals regardless of the extent of their experiences of managing suicidal presentations (Chandler et al., 2015; Bajaj et al., 2008; Michail & Tait, 2016). Others only included individuals with experience of working with self-harm or suicidal presentations (Leddie et al., 2021; Briggs et al., 2017). In Reid et al.'s (2024) study, participants were only included if they had worked in the service for a minimum of 3 months, ensuring they had sufficient time to experience presentations of suicidality in their clinical practice, while in Saini et al. (2016) and Saini et al (2010) GPs were contacted and invited to participate based on them being the named GP on a patient's file, ensuring all participants have had experiences of suicidal presentations in their clinical practice.

Overall, the quality of ethical considerations was noted to be quite variable. In Bajaj et al. (2008), Fox et al., (2015) and Saini et al., (2010) the authors did not disclose whether they had obtained ethical approval or consent from participants prior to conducting the research, while Saini et al., (2016) and Chandler et al., (2015) only reported having obtained consent but did not report whether they had received ethical approval from the NHS Heath Research Authority and/or other appropriate ethical boards. In contrast, Briggs et al. (2017) and Reid et al. (2024) acknowledged their adherence to the NHS HRA ethical protocol, alongside their careful consideration of the wellbeing of participants, given the sensitive and potentially distressing nature of the topic. The remaining studies (Leddie et al., 2021; Michail & Tait, 2016) also outlined that they had received the appropriate ethical approval and consent, although they do not provide further details on this.

Not all studies included a clear statement or table/diagram of the main findings (Michail & Tait, 2016; Bajaj et al., 2008; Briggs et al., 2017; Saini et al., 2010). However, the findings across each of the papers were well-presented, with clear themes and sub-themes emerging, as they effectively linked the findings to the research question. Each of the papers spoke to a rigorous process of analysis, including validation, review, and/or auditing of findings and themes. Reid et al. (2024), Briggs et al. (2017) and Leddie et al. (2021) were considered to have the strongest methodological rigour by the CASP tool. In Reid et al. (2024), the authors reported on their background and experience, acknowledging their position and potential influence on the research. They also outlined the process they took to ensure they minimised any bias during the recruitment and analysis stages of the study, increasing the rigour of their findings. Similarly, in Leddie et al. (2021), the authors acknowledged their process of conducting a bracketing interview and utilising reflexive logs and discussions to facilitate reflexivity, identify and reduce any researcher bias or impact. Briggs et al. (2017) reported that biases were reduced through team reflections and having two team members conduct interviews with participants. Michail and Tait (2016) noted that participants were informed of the researcher's professional status, but their backgrounds were not disclosed, which would have strengthened the rigour of this study. Other studies did not make any reference to reflexivity or the positioning of the authors (Bajaj et al., 2008; Fox et al., 2015; Saini et al., 2010, 2016), resulting in lower methodological rigour as per the CASP tool.

Synthesis of Findings

Three analytical themes and three subthemes were generated following the data synthesis. The main themes include: 1. Deducing the degree of risk; 1.1 Risk on a continuum; the professional's perspective, 1.2 The individual's context, 1.3 The double edge of support. 2. The emotional impact; living with uncertainty and accepting the limitations, and 3. Growth through training and experience (see Table 3 for a summary of themes and subthemes).

Table 3

Summary of Analytical and Subthemes from the Thematic Synthesis

Analytical Themes	Subthemes
Deducing the degree of risk	Continuum of risk: the professional's perspective The individual and their context 'The Double Edge' of support
The emotional impact; living with uncertainty and accepting the limitations	
Growth through training and experience	

Theme one: Deducing the degree of risk.

Each of the nine studies (Saini et al., 2016; Bajaj et al., 2008; Saini et al., 2010; Chandler et al., 2015; Reid, et al., 2022; Fox et al., 2015; Briggs, et al., 2017; Michail & Tait, 2016; Leddie, et al., 2021) highlighted various factors that professionals focused on to deduce the level of suicidal risk for the individuals they saw in clinical practice. This theme focuses on professionals' understanding of suicide risk as existing along a continuum. However, the assessment of where individuals fall on that continuum is shaped by the subjective judgments of the professional. The theme also highlights the importance of considering an individual's unique context when evaluating the level of risk.

Sub-theme: Continuum of risk; the professional's perspective

Five of the studies supported the idea that suicide related risk existed on a continuum, with self-harm on one end and suicide on the other. Professionals spoke about suicidal presentations ranging in severity from self-harm and fleeting suicidal thoughts to "*passive ideas about wanting to disappear"* (Reid et al., 2024) or wanting to escape their emotional distress (Chantler et al., 2015), and finally, clear intentions to die or plans to act on suicidal thoughts (Reid et al., 2024). However, determining the level of seriousness and intent regarding the behaviours along the continuum appeared dependent on the subjective perspective of the professional conducting the risk assessment and the meaning they ascribed to the individual's presentation, which varied considerably across the studies. In Reid et al. (2024), clinicians reportedly took all levels of suicide ideation seriously, including moments of '*dark despair'* that clients experienced and any thoughts of wanting to "*disappear*" where no clear expression to die was made. This was also noted in Fox et al. (2015), where practitioners expressed that it should never be ignored. However, other professionals understood self-harm to hold a different function, including "*relief from their anxieties and stresses"* (Chandler et al., 2015) or as a way of coping (Fox et al., 2015), rather than an indication of suicide. Nevertheless, it was also acknowledged that having a history of self-harm had resulted in a later suicidal attempt for some individuals (Saini, et al., 2016). Some clinicians also alluded to viewing self-harming behaviours as a form of "*get[ting] some attention, or some help*" (Michael & Tait, 2016) with many clinicians describing it as "*attention seeking"*(Chandler et al., 2015) and a "*cry for help"* (Saini et al., 2016; Chandler et al., 2015; Michail & Tait, 2016), generally noting self-harm to be lower risk and an expression of distress rather than a suicide attempt or indicator of potential future suicide. Nevertheless, professionals in the same studies also employed the terms '*cry for help'* and *'attention seeking'* when talking about more serious forms of suicide risk, including overdoses, reflecting that risk is a complex process where the level of seriousness is centred on the clinician's perspective and interpretation.

Some professionals across the studies also indicated that they felt individuals who were particularly high risk and intent on completing suicide would not inform them (Michael & Tait, 2016). They believed that individuals who did not disclose their suicidal thoughts or ask for help were often at greater risk of completing suicide, viewing those who avoided contact or disengaged from services as being at the highest risk (Briggs, et al., 2017). Furthermore, some professionals perceived individuals who openly expressed suicidal ideation as unlikely to be genuinely intent on ending their lives, viewing them as "not trying to kill themselves" and unlikely to "follow through" with suicide (Chandler et al., 2015). While one professional acknowledged the importance of taking such disclosures seriously, there was a general perception that individuals with a history of multiple expressions of suicide were at lower risk of completion, based on the belief that "they would have done it by now, if they were going to" (Briggs et al., 2017).

Overall, many professionals felt that those who remained in contact with services were less likely to act on any suicidal thoughts they may have (Briggs, et al., 2017; Saini et al., 2016) and therefore were often viewed to be less 'risky'. Clinicians spoke about self-harm behaviours being 'less worrying' (Saini et al., 2016) but noted experiencing an underlying 'fear that remained in the background" about risk (Chandler et al., 2015; Fox et al., 2015). Many of the examples highlighted across the studies support the idea that determining the degree of risk in clinical practice is a subjective experience based upon the professional's interpretation of risk behaviour. The category of risk within which professionals deem an individual to fall is subject to the meaning the individual professional ascribes to the presenting thoughts or behaviours, which is likely shaped by previous experience and understanding. How a professional interprets the behaviour directs the actions they take in response to their risk assessment and can therefore have significant implications for the individual's treatment. This idea gives rise to the notion that the task of assessing risk, which is standard practice for professionals in healthcare, is not a straightforward or concrete activity, and is complicated by professionals' perspectives and experiences with suicide related risk.

Sub-theme: The individual and their context

The need to understand and consider the individual's particular context when determining the degree of risk present was also supported by many of the studies. Clinicians described the need to gather an accurate picture of the individual's unique context and circumstances to assess risk reliably (Michail & Tait, 2016). Some practitioners highlighted the social and emotional difficulties, including interpersonal difficulties, poverty, financial uncertainty, substance misuse, inconsistent living arrangements, and relationship difficulties, as frequent contributors to experiences of suicidality (Chantler et al., 2015; Saini et al., 2016), with professionals being less able to differentiate between lower and higher risk behaviours when the individual faced many adversities. Understanding individuals' early life experiences was considered important, as difficult early life experiences were noted to increase suicidal experiences for some individuals. For example, in Reid et al. (2024), a mother's experience of childhood abuse was seemingly thought to contribute to increased suicidal experiences due to a desire not to want to repeat the cycle of abuse and believing they may be at risk of becoming an abuser themselves.

Nevertheless, other aspects of the individual's context were considered important in terms of protective factors such as the existence of a good support network (Reid et al., 2024; Briggs et al., 2017). Professionals emphasised the importance of 'knowing the individual well' (Bajaj et al., 2008) and understanding their context, including their mental and physical health histories, to comprehensively assess the level of risk involved. The existence of an established diagnosis, such as depression or psychosis, or a chronic pain condition, appeared to support professionals in being more open with their clients in asking about suicidal thoughts or behaviours (Bajaj et al., 2008), and enabled them to infer the meaning behind presentations better and subsequently determine the risk. Clinicians also spoke about needing to approach the topic with sensitivity and use language that reflects the individual's language. (Fox et al., 2015). Others highlighted the need to take into account the individual's culture and language when considering risk (Bajaj et al., 2008), with some professionals noting their uncertainty around "cultural attitudes to suicide" for individuals from ethnic minorities as a potential barrier to assessing risk (Bajaj et al., 2008). Other professionals considered an individual's preference and autonomy important when managing and treating suicidal presentations. They reported that it was difficult when they had limited options to offer (e.g only medication), with professionals noting that this reduced autonomy and impacted outcomes for their clients (Saini et al., 2016).

Sub-theme: 'The Double Edge' of Support Systems

Many of the studies supported the idea that professionals experienced their clients' interpersonal relationships and contexts as double-edged when considering suicide related risk. It alludes to the multilayer process of determining the level of risk and the factors that might be influencing it. Various professionals noted that a client's relationship with others could exhibit protective elements that reduced their risk of suicide, yet they could simultaneously increase the risk. In Reid et al. (2024), professionals reflected on the complex relationship between postpartum mothers and their newborns, and how this bond can influence a mother's experience of suicidality. For some women, the connection with their baby and the act of caring for them, such as through feeding, was seen as a protective factor, offering a sense of purpose and emotional grounding. However, for others, the baby could serve as a painful reminder of birth trauma or be perceived as the cause of their suffering, potentially intensifying feelings of distress. Clinicians in the study highlighted the double-edged nature of breastfeeding in this context. On one hand, successful breastfeeding was described as a source of emotional connection and a reaffirmation of maternal adequacy, with professionals noting that being the one person who can nourish the baby may instil a sense of irreplaceable value, which could help guard against suicidal thoughts. On the other hand, when breastfeeding did not go as planned, professionals observed that it often led to feelings of failure or inadequacy in mothers, which in turn could heighten their vulnerability to suicidal ideation and behaviours during the postnatal period.

An individual’s relationship with their broader support network was also described as a double-edged sword. While many clinicians viewed family involvement as a valuable resource for both the individual and the clinical team in managing suicide risk and supporting recovery (Michael & Tait, 2016), others reported that family members could sometimes “hinder” progress (Michael & Tait, 2016) or even “exacerbate the problem” (Leddie et al., 2021) or be a barrier to accessing support (Fox et al., 2015). Some clinicians felt that family presence could discourage openness from the individual (Michael & Tait, 2016), while others noted that certain families responded punitively due to a lack of understanding, hoping such responses would put an end to the risk behaviours (Leddie et al., 2021).

Similarly, in Reid et al. (2024), the presence of a supportive network was considered vital for reducing the risk of suicidal thoughts among newly postpartum mothers. However, professionals also observed that this support could sometimes feel “overbearing,” contributing to feelings of not being “needed” and potentially diminishing the mother's sense of purpose which may weaken the protective role such support might otherwise play.

Peer relationships were also noted as having both positive and negative influences on suicidal behaviours. In Briggs et al. (2017), clinicians acknowledged that peer support and group connections could foster recovery by offering safety, a sense of belonging, and mutual understanding (Bajaj et al., 2008; Briggs et al, 2017). However, there were also concerns that such connections could reinforce or encourage suicidal behaviours. One clinician described peer relationships among young people as a “trellis” upon which suicidal behaviours may “crystallise and grow” (Briggs et al., 2017). Similarly, clinicians reflected on the dual role of social media, particularly among young people (Briggs et al., 2017; Bajaj et al., 2008). While online platforms were seen as providing opportunities for meaningful and supportive connections beyond the family, an important aspect of adolescent development, some clinicians observed that specific individuals appeared particularly vulnerable to the “social transmission of suicidal behaviour” through exposure to online groups, media, and peer interactions (Briggs et al., 2017), which could have harmful consequences.

Theme Two: The Emotional Impact; Living with Uncertainty and the Limitations of the System

Each of the studies (Reid et al., 2024; Saini et al., 2016; Bajaj et al., 2008; Chantler et al., 2015; Briggs et al., 2017; Leddie et al., 2021; Michail & Tait, 2016; Saini et al., 2010; Fox et al., 2015) contributed to the idea that working with suicide-related risk, including self-harm, had a significant emotional impact on professionals, both personally and professionally. Clinicians described experiences of ‘professional isolation’ (Saini et al., 2016) and a sense of powerlessness or "heartsink" (Michail & Tait, 2016) when supporting individuals presenting with suicidal thoughts and behaviours. One nurse, working in a community setting, spoke to the profound sense of responsibility and isolation that can arise when they are the sole practitioner involved in the care of a high-risk individual, stating that they felt they had the person's “whole life in [their] hands” (Leddie et al., 2021).

Although professionals acknowledged that such situations were often “emotionally draining,” “stressful” (Leddie et al., 2021), and “demanding” (Saini et al., 2016), with some describing feeling “quite burnt out by it all” (Briggs et al., 2017), others reflected on the privilege of their role. For instance, some considered it a “huge honour to work with people when they are so vulnerable” (Leddie et al., 2021). Alongside a deep sense of responsibility for clients’ recovery, professionals also expressed sadness when clients perceived self-harm or suicide as their only option. At times, these feelings were accompanied by frustration; however, many clinicians reported experiencing “shame” when they noticed themselves feeling “angry” at the client or when they internalised the client's risk as a personal failure (Leddie et al., 2021). Additionally, there was a prevailing notion among professionals that they were expected to manage and suppress their emotional responses, acting as a “container” for their clients’ distress in order to support the recovery process (Leddie et al., 2021).

The unpredictability of suicide risk, coupled with systemic limitations within the UK healthcare system, appeared to fuel the emotional toll experienced by professionals. Clinicians acknowledged the persistent need to “always live with uncertainty” (Chantler et al., 2015), often describing their practice as walking a “bit of a knife-edge” when managing risk (Briggs et al., 2017). One professional expressed never feeling truly “confident… with a mental health assessment, about when someone feels like they are genuinely at acute risk” (Chantler et al., 2015), while others described taking these concerns home, worrying “at the end of the day [and] thinking what’s gonna happen?” (Briggs et al., 2017).

Time constraints and overwhelming workloads were also reported as significant barriers to adequately identifying and managing suicide risk (Michael & Tait, 2016). Some participants admitted they lacked sufficient time to conduct thorough suicide risk screenings (Bajaj et al., 2008), with concerns that initiating conversations around suicidal ideation might “open a bag of worms” or inadvertently “make things worse by suggestion” (Bajaj et al., 2008) or have a ‘negative outcome’ (Fox et al., 2015).

In primary care settings, clinicians found it challenging to refer high-risk individuals to secondary or specialist services. They often felt dismissed or that their referrals were not treated with appropriate urgency (Chandler et al., 2015; Saini et al., 2010; Fox et al., 2015). One professional described feeling compelled to "manipulate the system" to ensure their concerns were taken seriously. At the same time, another reported feeling "frustrated and helpless" when unable to fulfil their professional responsibilities due to systemic barriers (Saini et al., 2016), including long wait lists and rigid criteria (Saini et al., 2010). Concerns were also raised about individuals becoming lost in the complex "referral maze" within the UK's healthcare system, with professionals frequently excluded from decision-making processes concerning those they had referred (Saini et al., 2016). Professionals shared that they were left feeling unsupported (Saini et al., 2010) and trying to provide a 'stopgap' when referrals are not accepted, but there is no alternative supports available.

Due to limited-service provision and resource constraints, some clinicians noted relying on short-term interventions that, while not ideal for long-term outcomes, were the best options available for managing immediate risk (Saini et al., 2016). Despite these challenges, professionals identified strong inter-service communication and collaborative relationships as valuable supports in managing risk (Saini et al., 2016; Saini et al., 2010). Additionally, maintaining personal wellbeing and prioritising self-care were seen as essential strategies for coping with the emotional demands of working with suicidal individuals (Leddie et al., 2021).

Theme three: Growth through education and experience

In addition to navigating the emotional demands, uncertainty, and systemic barriers inherent in suicide risk management, the majority of the studies highlighted that many professionals do not feel adequately trained or experienced in responding to suicidal behaviours within their roles. This was particularly evident among general practitioners

(GPs), who often encounter mental health difficulties as a secondary concern. Several GPs reported having received no formal training in suicide risk screening (Bajaj et al., 2008; Saini et al., 2010), while others noted only limited exposure through specialist posts or professional development courses. As a result, clinicians expressed varying levels of confidence in their ability to assess and manage risk.

Some professionals admitted to lacking the confidence to carry out risk assessments independently and preferred that individuals presenting with self-harm or suicidal ideation be assessed by “specialists” (Chandler et al., 2015; Saini et al., 2016; Saini et al., 2010; Fox et al., 2015), citing insufficient training or expertise. Others emphasised the need for more “specialist education” and ongoing targeted training and practical information to enhance their ability to recognise and respond to risk in clinical settings (Michail & Tait, 2016; Fox et al., 2015).

Nonetheless, a small number of clinicians described themselves as “confident and assured” in conducting risk assessments, stating that they did not find the task “difficult” and even regarded it as “straightforward” (Chantler et al., 2015). One professional reflected on the importance of experience in building confidence, highlighting the value of “learning on the job” as a means to “grow as a clinician” while navigating the “rollercoaster of emotions” that come with the work, ultimately fostering resilience (Leddie et al., 2021).

Several clinicians also described developing an intuitive approach, learning to “trust their gut” when assessing risk, a skill that, they noted, evolved through practice and repeated exposure (Chandler et al., 2015). Some nurses spoke about becoming “hardened” or “desensitised” through ongoing engagement with high-risk presentations, which they felt allowed them to manage both the clinical demands and the emotional strain more effectively (Leddie et al., 2021).

The importance of supervision and “shared learning” through multidisciplinary collaboration was also widely recognised. Professionals described how working within a team allowed them to “tolerate” the risks, emotions, and uncertainty associated with suicide prevention (Leddie et al., 2021). One clinician highlighted the value of “the opportunity to reflect on challenging experiences... and to be supported in understanding why such experiences occur and how they can improve their responses in the future” (Leddie et al., 2021). Practitioners working outside of multidisciplinary teams also expressed a strong desire for such collaborative support, underscoring the crucial role of interprofessional relationships in managing suicide risk effectively.

Discussion and Conclusion of the Systematic Literature Review

This literature review is the first qualitative synthesis to explicitly explore the experiences of professionals around managing suicidal presentations within community-based services in the UK. A notable strength of this review lies in its inclusion of studies that span both adult and child service settings, providing a deeper understanding of professionals' experiences overall. Furthermore, the diversity of professional roles represented across the included studies, ranging from GPs, consultant psychiatrists, and psychologists to nurses and social workers, offers a comprehensive view of how different professionals experience and approach suicide risk in clinical practice.

Gaps identified within the current literature

In light of the limited research available on the research question, a literature search was conducted to explore professionals' experiences of navigating suicidality in community healthcare settings more generally. Of the nine studies included in this review, none of them explicitly identified whether the professionals’ experiences with suicidality involved working with any individuals with LD or other developmental or cognitive impairments. Subsequently, it remains unclear whether clinicians working in LD-specific services in the

UK face similar experiences as those in other services, or whether it is qualitatively different for those working in LD services. In addition, the review highlights a lack of literature surrounding the experiences of clinicians working in community-based specialist services, with most research having been conducted in primary care settings. This provides a further rationale for the current project, which seeks to amplify the voices of professionals working with suicidality within an NHS community service for adults with LD.

Aim of Current Research

As previously outlined, the current research aims to explore the experiences of professionals working with suicidality within community-based services for individuals with LD. Specifically, it seeks to gain deeper insight into how suicidal thoughts and behaviours present in this population, as understood by professionals supporting them. The study also aims to identify the challenges and barriers professionals may encounter in assessing and managing suicide risk, and to consider the implications these experiences may have on clinical practice, service provision, and professional wellbeing.

Chapter Three: Methods

Chapter Overview

This chapter outlines the research design and methodological approach employed throughout the current study. It will present the research procedure, including the process of recruitment, data collection, and data analysis, alongside the ontological and epistemological paradigms that underpin the study. Reflexivity and a self-reflexive statement are provided outlining the researcher's background and experience, acknowledging the relative influence of my own beliefs and values on the research process and interpretation of findings. The chapter will also discuss any ethical considerations and concerns related to this research and outline plans for review and dissemination of research findings.

Philosophical Framework

Foregrounding a research philosophy, including the ontological and epistemological positions of the researcher, is a crucial aspect of the research process, as it underpins and influences numerous methodological decisions (Silverman, 2013; Scotland). These philosophical stances shape how researchers view the world and inevitably inform research design, and the approach to data analysis and interpretation (Braun & Clarke, 2021). For example, a positivist stance posits that knowledge can be objectively measured and acquired through methods that aim to establish causality and identify patterns among variables (Park, Konge, & Artino, 2020). This position aligns more closely with quantitative research methods, which have traditionally been prioritised in the social sciences due to long-standing assumptions that they offer increased rigour, objectivity, and generalisability (Millsap & Maydeu-Olivares, 2009; Park et al., 2020). However, qualitative approaches have increasingly gained legitimacy and recognition, particularly within health and social care research, for their capacity to explore complex, personal, and subjective experiences in depth, offering insights that are often inaccessible through quantitative methods alone (Braun & Clarke, 2013; Al-Busaidi, 2008). Qualitative research is generally grounded in interpretivist paradigms that reject the notion of a single objective reality, instead emphasising the importance of subjective meaning and experiences of social phenomena (Flick, 2014; Willig & Stainton Rogers, 2017). This approach prioritises understanding patterns, variations, and contextual meaning over establishing cause-and-effect relationships.

Ontological and Epistemological Positionalities

Ontological Positioning.

Ontology concerns the nature of reality and is often described as the "science of being" (Crotty, 1998). Ontological positions reflect an individual's beliefs about what constitutes existence and reality (Lincoln & Guba, 1985; Smith, 2012), and whether reality exists independently of human perception or is constructed through social interactions and meanings (Ormston et al., 2014). It also questions whether a shared, universal social reality can exist, or whether realities are inherently context-specific (Ormston et al., 2014)

Ontological positions are typically thought to exist on a continuum, with realism and relativism views representing opposing ends. Realist ontology posits that a single, objective reality exists independently of our perceptions, one that can be observed, measured, and understood as a 'truth' through rigorous research (Giddens, 1974). This stance aligns closely with quantitative research, which aims to generate generalisable, replicable findings (Carson et al., 2001). From a realist perspective, objectivity is paramount, and it is assumed that findings can be presented without researcher bias (Lyons & Coyle, 2016).

In contrast, a relativist ontology holds that reality is socially and contextually constructed, shaped by interactions, interpretations, and individual or cultural meanings (Fletcher & Fitness, 1996; Nightingale & Cromby, 1999, 2016). Rather than seeking a single ‘truth’, this perspective acknowledges that multiple realities exist, emphasising the fluid nature of reality and how understandings shift across various perspectives and experiences.

Positioned between the two ends of the ontological continuum is critical realism, which underpins this research. This position acknowledges the existence of an objective reality while recognising that our understanding of that reality is shaped by social and cultural structures and constructs, discourses and subjective influences (Guba, 1990). Critical realism posits that although realities exist independently of human perception, our ability to access and interpret them is inherently mediated by personal, social, and contextual factors (Madill et al., 2000). This philosophical stance allows for a nuanced exploration of how individuals perceive and experience reality in distinct ways. For instance, in the context of NHS LD services, the diagnosis of LD functions as a real and measurable construct, reflecting a realist approach to classification. However, individuals will experience and attach different meanings to this diagnosis, shaped by their personal histories, social interactions, and cultural context. Critical realism thus accommodates both the objective reality of diagnostic categories and the subjective, lived experiences of professionals working with these presentations. These experiences are understood to be influenced by factors such as system structures, personal experiences and beliefs, alongside broader societal discourses. As a researcher, I adopt the view that each participant’s account is valid within the context of their lived reality, and different staff members may have differing, but equally meaningful, interpretations of their work, shaped by wider structures and environments in which they operate.

Epistemology Positioning.

Epistemology refers to the study of knowledge and centres around what constitutes valid knowledge and how it is acquired. It addresses fundamental questions about the nature, scope, and limits of knowing, including what is possible to know (Braun & Clarke, 2013). An epistemological stance frames how researchers approach their study, shaping the process through which knowledge is discovered and interpreted about a particular phenomenon.

Epistemological positions are also conceptualised as being on a continuum, with objectivism at one end and subjectivism at the other. An objectivist epistemology posits that meaning and reality exist independently of the individual mind (Crotty, 1998; Moon & Blackman, 2014). In contrast, subjectivist epistemology assumes that reality, and it's relative meaning, is not discovered but instead constructed. Reality and its interpretation are seen as being shaped by the dynamic interaction between the individual and the object, which aims to uncover how they shape their perception of the world (Moon & Blackman, 2014)

Critical realism, on the other hand, sits between the polarisation of objectivism and subjectivism. This stance rejects the objectivist view of truth and knowledge, instead proposing that knowledge is socially constructed and influenced by the relational dynamics between the participant and researcher (Ponterotto, 2005), with the researcher having an active role in the outcome (Hofer & Pintrich, 1997). It takes into consideration that individuals may construct meaning in different ways, even about the same phenomena and that knowledge takes place within particular conceptual and social frameworks.

Importantly, it acknowledges the fallibility of human understanding and emphasises the need for critical reflection on the social and historical context in which knowledge is generated. From this epistemological perspective, which has been adopted for the present research, knowledge and reality are understood to exist integrally (Bhaskar, 1978), whereby reality cannot exist without the context of knowledge. The constructs of LD and suicidality, which are at the core of this research, along with their respective historical contexts, provide the setting within which the study takes place and data is collected. Furthermore, the data produced by this thesis is influenced by the participants' interpretations of the two constructs and the lens (e.g age, cultural background, gender, history) through which I view their perceptions and understandings.

Study Design

Qualitative research seeks to gain a deeper understanding of human experiences and social phenomena that cannot be captured solely through quantitative data (Silverman, 2013; Sandelowski, 2004). It offers rich, in-depth insights into a wide variety of phenomena and holds a valued place within evidence-based healthcare. It has contributed to various aspects of care, including patient safety, prescribing, and understanding various illnesses and disorders, while offering contextual understandings surrounding aspects of care, such as the effectiveness of interventions, which would be limited using quantitative methods alone (Denzin & Lincoln, 1994). Given the exploratory nature of the current study and its focus on understanding professional experiences, a qualitative methodological approach, grounded in a critical realist epistemology, was deemed most appropriate.

Qualitative methodologies: contemplating the approach

Various analytical methods can be used in qualitative research designs aimed at identifying patterns and themes of meaning across data (Braun & Clarke, 2006). This includes interpretative phenomenological analysis (IPA; Smith et al., 1999), Grounded Theory (GT; Glaser, 1992), Narrative Analysis (NA), and various forms of Thematic Analysis (TA), including reflective TA (Braun & Clarke, 2021, 2022).

IPA is a methodological approach that predominantly focuses on understanding how individual participants make sense of their personal and social world within a specific context. In addition to being constrained and underpinned by phenomenological epistemology (Smith & Osborn, 2007), it is idiographic in its approach, focusing on detailed and in-depth analysis of individual experiences rather than generalisations of experiences. It utilises a homogeneous sample, where subjects exhibit common key characteristics, such as demographics, across small groups of 6-8 participants (Smith & Osborn, 2003). In light of the aims of the current research and the limited research conducted on this specific topic, it felt important to consider some diversity or heterogeneity within a larger sample of participants. For the current study, all participants were required to work in LD services. However, the project aimed to include a variety of professionals to identify patterns or themes from multiple perspectives, and therefore, this approach did not align with this.

The primary focus of GT is on generating or developing a theory regarding a social phenomenon or social process of interest that is grounded in the data itself (McLeod, 2001). Unlike TA, it seeks to uncover patterns that lead to an explanatory theory (Glaser & Strauss, 1999; Crotty, 1998), utilising a constant comparison analysis process (Crotty, 1998). Although this approach would elicit themes representing the data, the current thesis was not explicitly aimed at generating a theory to explain the experiences of staff; instead, it aimed to generate further understanding of their experiences in clinical practice.

NA approaches focus on the way individuals construct stories or narratives to organise and make sense of their experiences (Riessman, 2008). The primary focus of this approach lends itself to understanding how individuals narrate their stories, when and why they prioritise certain stories over others (Wells, 2011), while eliciting how these stories reveal insights into participants' values, cultural, and social contexts (Esin et al., 2014). This method of analysis offers rich and in-depth insights into experiences and social phenomena, yielding a holistic understanding of lived experience. Although understanding how professionals make sense of suicidality through storytelling would support the aim of the current research, disseminating patterns and common themes of shared experiences that emerge from participants' responses, which align with TA approaches, might be more easily received and relatable to a broader audience than could be attained from NA approaches.

As noted, TA is a qualitative approach that aims to understand patterns or themes of meaning surrounding a phenomenon of interest. The approach is independent of specific theoretical and epistemological underpinnings, suggesting that it can be applied flexibly across various theoretical and epistemological frameworks (Braun & Clarke, 2006). TA has also been considered a beneficial approach that can be utilised to examine the perspectives of different research participants, highlight any similarities and differences, while also uncovering any unexpected insights (King, 2004). TA was viewed as an appropriate method for this study as it allowed a broad overview of themes to be identified, alongside ascertaining links across the participants' opinions and perspectives, including similarities and differences. TA can be used to build upon previous related research or provide insights into exploratory research of under-researched topics (Braun & Clarke, 2006).

Reflective Thematic Analysis

Despite the existence of various typologies of TA, Braun and Clarke's TA approach is arguably one of the most thoroughly defined methods for conducting TA (Byrne, 2021). Although originally outlined in their 2006 publication, Braun and Clarke have since clarified and refined the approach now coined as 'Reflexive Thematic Analysis'. Frequent misunderstandings of the initial outline of the approach led many researchers to not adequately adhere to it, which became a significant criticism of the framework of analysis. This prompted Braun and Clarke to clarify some of the misconceptions through further writings and publications, thereby helping researchers better understand the approach. They encourage researchers implementing their TA approach to thoroughly review their most recent publications to fully honour and adhere to their contemporary RTA approach (see Braun & Clarke, 2006, 2013, 2019, 2022). Braun and Clarke (2013) assert that the approach can be applied to a variety of research, including both descriptive and exploratory studies. It is also considered applicable to investigating semantic (descriptive, surface-level) as well as more interpretative types of research that explore meaning on a deeper, more latent level. The reflexive approach to TA acknowledges the researcher’s active role in the production of knowledge (Braun & Clarke, 2019). The data and findings are acknowledged to represent the researcher’s interpretations of the themes and patterns of meaning that emerge from the data. More explicitly, this type of analysis is thought to reflect the researcher’s interpretation of the patterns that emerge at the intersection of the dataset, the theoretical assumptions underlying the analysis, and the researcher's analytical skills (Bruan & Clarke, 2019). RTA is centred on “the researcher’s reflective and thoughtful engagement with their data and their reflexive and thoughtful engagement with the analytic process” (Braun & Clarke, 2019, p. 594). Although posited by some researchers as a criticism of the approach (e.g., Boyatzis, 1998), the RTA approach fully appreciates and embraces the subjectivity and creativity aspects of the approach as a resource in the production of knowledge. The researcher’s subjectivity and the practice of reflexivity, as outlined by the model, are considered key to its successful application (Braun & Clarke, 2022). Furthermore, it enables transparency and credibility through the explicit sharing of the researcher's decision-making process, as well as the theoretical positioning and analysis enactment (Braun & Clarke, 2006, 2022). Furthermore, TA has been widely applied in qualitative research and was deemed the most appropriate approach to match the research aims of this study.

Reflexivity

Qualitative research, as previously noted, is fundamentally intertwined with subjectivity. It is a valuable and important aspect of qualitative research (Braun & Clarke, 2022), where acknowledging and engaging with how the researcher’s perspectives influence and shape the research process is an essential element (Barratt et al., 2020). The process of reflexivity refers to the researcher’s awareness of, and engagement with biases and assumptions, as well as the process by which they account for how personal, relational, and contextual factors shape the research (Olmos-Vega et al., 2023). This awareness enables researchers to critically reflect on their interpretations, ensuring the validity, credibility and rigour of the research and findings. In addition to fostering transparency and trustworthiness as a researcher, the process of reflexivity encourages researchers to delve deeper into their assumptions and preconceptions, arriving at a more nuanced and enriched understanding of the phenomena under investigation (Braun & Clarke, 2022). The following sections outline some of the researcher's key experiences and perspectives that may have shaped this research. In acknowledgement of the impact of these, parts of the following section are presented in the first person as recommended by Reid (1991).

Self-Reflexive Statement

Background. I am a 34-year-old white Irish woman, raised in a small village in the west of Ireland. I am a wife, mother, and the middle of three sisters. My academic background includes a Joint Honours BA in Psychology and Mathematics from the University of Limerick (2008–2012), followed by a Higher Diploma in Integrative Psychotherapy. In 2015, I relocated to the UK to gain experience in psychology and mental health, initially working on an adolescent inpatient ward, followed by a role in an Early Intervention in Psychosis service. I began Clinical Psychology training at the University of Essex in 2021. Clinically, I enjoy working with families, drawing on integrative, strength-based approaches with a particular interest in systemic, narrative, and third-wave CBT models. I value creativity in therapy and utilise mediums such as art and play to support engagement.

Relationship to the Research. Throughout my clinical experience, I have encountered many individuals experiencing suicidality, and understanding experiences of suicidality has long been an area of interest, both professionally and personally. I am particularly curious about the factors that drive or protect individuals from suicide and how suicidality may present differently across groups. A family member's experience with suicidal thoughts further deepened this interest.

A pivotal moment occurred for me when I conducted a risk assessment with a person with an LD who was also experiencing psychosis. When asked about suicidal thoughts, the individual stated that they wanted to die but did not have any way to do it. Determining the person's level of understanding of suicide, and their perceived capability to engage with risk behaviours was difficult, leaving me feeling unclear and uncertain about the inherent risk present. This led me to consult supervision and review the literature concerning suicide risk in the LD population, where the lack of guidance and minimal research specific to this became evident. This experience directly underpinned the focus of my thesis and fostered my curiosity to know more.

Reflecting on my background and growing up in rural Ireland which has ultimately shaped my understanding of the core concepts of thesis, including LD and mental health, and suicidality. While Ireland and the UK share similarities in the historic treatment of this population, Ireland's shift away from institutionalisation and outdated terminology has arguably been slower. Terms like "handicapped" for LD and "mad" for mental illness were still frequently used throughout my childhood, reflecting broader societal attitudes, though they do not reflect my opinion. Furthermore, the dominance of the Catholic Church in Ireland saw suicide being viewed as a sin and punishable by similar means as outlined in the history of it in the UK. Nonetheless, I grew up at a time of transition, and having family members experience severe mental illnesses as a child was foundational for me in developing a compassionate and caring understanding of those experiencing difficulties, an approach that has shaped the researcher and clinician I am and continue to aspire to be. This experience has also stemmed a commitment and desire to challenge stigma while improving services for vulnerable individuals.

My professional background, as a current trainee clinical psychologist, has also inevitably formed assumptions about the experiences of staff working with suicidality. While I commenced this study more from an ‘outsider’ position (Gallais, 2008), having had minimal experience working with individuals with LD, I am a professional working in NHS services and therefore sat between an ‘insider’ and ‘outsider’ position. I transitioned towards an ‘insider’ position partway through the research process when I commenced my third-year placement in the local LD team, increasing my exposure to this client group, and the experiences of suicidality. To manage any potential bias arising from this, I maintained a reflexive journal throughout the study, documenting how my context and any assumptions may have influenced the research process (Malterud, 2001). The journal (see Appendix C for extracts from the journal) promoted transparency in my analytical decisions (Lincoln & Guba, 1985) and facilitated my reflexive engagement with participants and data interpretation (Maxwell, 2012).

Data Collection

Semi-structured interviews were deemed the most appropriate means for data collection in uncovering the perceptions of how suicidality presents amongst individuals with LD in clinical practice. This style of interview is highly prevalent in TA (Bradford & Cullen, 2012) and enables the participant to reveal their views and perspectives on the subject being investigated. The semi-structured nature of the interview, where the discussion is guided by a topic guide rather than fixed questions, aims to facilitate participants in sharing their experiences in their own words (Melia, 1997). Employing this structure to interviews ensures that the interview addresses the research questions but is flexible enough that responses are not directive or able to be ‘predicted in advance’ (Wengraf, 2001, p.5) with “scope for the participants to raise issues the researcher had not anticipated” (Braun & Clarke, 2013, p.24). Subsequently, the interview process can generate a broad discussion in which complex issues can be probed and responses clarified to gain insight into the complexities of the participant's attitudes and behaviours, including how they understand phenomena (McCracken, 1988). It is anticipated that this method will provide unique insights into the experiences of staff in managing suicidality as it presents in clinical practice for individuals with LD.

Participants and procedure

Service context

Participants were recruited through an NHS community LD service for adults with LD, aimed at increasing independence and promoting improved health and quality of life. The service provides assessment, treatment and evidence-based therapy for individuals registered with having a LD whose needs cannot be met through standard mainstream services. The service consists of various multidisciplinary professionals, including psychiatrists, psychologists, nurses, occupational health professionals, dieticians, speech and language therapists, art therapists and support workers.

Sampling

Criterion purposive sampling was utilised for the study, whereby participants were selected based on their ability to provide information relevant to the research question. This non-random type of sampling involves selecting individuals who are proficient and informed about the phenomenon of interest (Etikan, Musa, & Alkassim, 2016) and willing to participate (Cresswell & Plano Clark, 2011). Therefore, in line with the research aims, participants were selected based on the criteria that they worked in LD services and had experienced working with a client with LD presenting with suicidality in their clinical practice, where suicidality was outlined as any presentation related to suicide, including ideation, behaviours and attempts. Additionally, snowballing was employed, where participants were asked to identify any colleagues who met the study's criteria. This type of sampling is considered a valuable way of recruiting participants in research regarding potentially emotive and sensitive topics, as being alerted to the study from individuals known to them may increase the chances of them coming forward to participate (Boehnke et al., 2011; Noy, 2008)

Regarding the sample size, various guidelines are available to determine an appropriate sample size. Sandelowski (1995) argues that for qualitative studies, the sample size should be small enough to manage the material and large enough to provide ‘a new and richly textured understanding of experience’ (p. 183). Guidelines for TA (Braun & Clarke, 2013) suggest that the dataset should be sufficiently large to identify patterns but small enough to maintain a focus on the participants' experiences (Braun & Clarke, 2013). Furthermore, they suggest that the sample size should be guided by the type of data collection and the size of the project, with small projects (e.g., undergraduate research) aiming to collect data from 6-10 interviews and 10-20 interviews for projects considered medium-sized (e.g., professional doctorate thesis). In line with these guidelines, the current study aimed to recruit and conduct between 10 and 20 individual interviews.

Research Procedure

An email detailing the purpose of the research study, including the inclusion/exclusion criteria, and instructions on how to participate, was circulated to all staff members working within the LD service. Individuals interested in participating were asked to contact the researcher using the contact details provided in the email. Those participants were then provided with an accessible information sheet describing the full implications of their involvement in the research (Appendix D). Participants were given at least 72 hours between receiving the participant information sheet and arranging a meeting, allowing them sufficient time to consider the study and its requirements, or clarify any information as needed to make an informed decision about participation. Participants who had experience working with clients with LD presenting with suicidality and who agreed to participate were then invited to take part in an individual interview with the researcher at a time that was convenient for them. Consent was obtained prior to each interview (see Appendix E for consent form)

Interviews were conducted via video using Microsoft Teams. All interviews were audio recorded and transcribed verbatim. Any identifying data was removed at the point of transcription, and each participant was allocated a pseudonym. Following transcription, the original recordings were deleted. All personal data and files were saved on a password-encrypted NHS laptop.

Materials

Interview guide

An interview topic guide was devised to provide a broad framework for the exploration of experiences and perceptions of professionals identifying, assessing and managing suicidal thoughts and behaviours experienced by individuals with LD. According to Arthur and Nazroo (2003), utilising a topic guide enables the researcher to ensure that all necessary topics and issues are covered, while also allowing for flexibility in how the conversation unfolds. While providing some structure, it also allows space to follow important details and leads from the participant. As a guide, it does not expect that all questions will be asked to each participant or asked in the same way during every interview (Arther & Nazroo, 2003).

The interview guide for this project was developed in collaboration with experienced clinicians working in LD services to ensure the questions would appropriately address the research aims. Following an initial consultation with clinicians, which included a clinical psychologist and two nurses from the local LD service, a draft outline of the interview questions was devised, which included open-ended questions and potential probes to facilitate participants to share their experiences relating to the topic of interest. Further consultation with the clinicians was sought to gather feedback and clarification on the interview protocol before finalising it. Interview questions were included to facilitate discussion concerning the individual's experiences of understanding, identifying, assessing and managing suicidal thoughts and behaviours in clinical practice. They included items such as: Tell me about your experience working with suicidality in LD populations. In your experience, how do individuals in this population experience suicidal thoughts or behaviours? How do they express this? What do you think contributes to suicidality for individuals in this population? What is your experience of assessing suicide risk with individuals with an LD? What are the challenges, if any, you have faced regarding this?

During the consultation, clinicians emphasised that asking questions about staff's experience with the support available to them when working with suicidality was particularly important. More explicitly, they felt that in order to ensure the project is meaningful within a clinical sense and to amplify the usefulness of findings, it would be important to ask about what support they found helpful in managing this, and what could be helpful to have in place, which may elicit some guidance for service improvement. As such, questions were asked to elicit what staff found helpful and what else might be needed for them to work more effectively with suicidality in this population. Furthermore, demographic information was collected about each participant during the interview process (see Appendix F for interview guide)

Reflective Journal

As mentioned above, the researcher kept a reflective journal alongside field notes throughout the research project. The journal helped the researcher become aware of and describe any feelings they experienced while conducting research related to this topic. It enabled the researcher to record their reactions, assumptions, expectations and biases about the research process (Morrow & Smith, 2000), which added rigour to this qualitative method of inquiry.

Ethical considerations

Ethical approval

Ethical approval was obtained by the NHS Health Research Authority (HRA) [23/LO/0300] on 24th May 2023 and the University of Essex Ethics Committee [ETH2223-1596] on 4th July 2023 prior to commencing the study. The participating NHS Trust also granted permission to conduct the study in the trust's LD service (see Appendix G and H for confirmation of ethical approval documents).

Protocol for managing a sensitive topic and potential distress

Given the potentially distressing and sensitive nature of the topic, a protocol was devised to support any staff who may have found our conversation distressing. Firstly, it was indicated in the participant information sheet that participants who felt that their participation in the study would likely elicit distress should consider not taking part. For those who consented to participate, the researcher and participant agreed on a plan together prior to commencing the interview, which outlined what would be done should they become distressed throughout the interview. This included reminding participants to inform me if they wanted to stop the interview and how they might do this if they were feeling overwhelmed or distressed. Collaboratively, we also explored steps that the researcher would take if the participant were to disconnect from the online interview due to increased distress. It was agreed that each participant would initially attempt to reestablish contact with the researcher. However, if the researcher were unable to do this, the thesis supervisor, who is an established employee of the local NHS LD services, would be alerted and requested to contact the participant. Participants were also provided with a debrief sheet outlining reminders of where they can seek further support if required.

Data Analysis

Data was analysed using RTA, as outlined by Braun and Clarke (2006, 2019, 2021, 2022), to generate themes that represent the data. The six-stage analysis approach consisted of the following steps, outlined in Table 4.

Table 4

Reflexive Thematic Analysis Process

Six Phases of RTA:	Steps Taken:
Familiarisation with the data	The initial stage of RTA consisted of steps to become immersed and familiar with the data. The process consisted of listening to and transcribing the interviews, followed by a period of reading and re-reading the transcripts, which helped become familiar with the data. The field notes were also reviewed, and an early initial map was drawn.
Coding	Through the identification of portions of the data that were seemingly 'interesting, relevant and meaningful for the research aims' (Braun & Clarke, 2022), initial codes were applied across each of the transcripts. Consistent with this approach, these codes were both semantic (explicit/surface meaning) and latent (conceptual/implicit meaning). The aim of the coding stage was not to summarise but to represent an analytical view of the data, and it was conducted using NVivo software (see Appendix I).
Generating initial themes	Following initial coding, the next step involved organising the codes and grouping related themes to identify shared patterns of meaning across the dataset. This process was conducted manually and using NVivo software to ensure a rigorous process of theme development and support the researcher's analytical thinking process (see Appendix J). This process of interpreting the potential connection between the codes was supported using mind maps to make sense of the analytical narrative emerging from the data and develop initial themes.
Developing and reviewing themes	Assessing the fit of the initial themes and reviewing them to ensure they accurately reflect the data was the next stage of the analysis. This process involved revisiting and refining the data and themes and re-coding where necessary. (see Appendix K)

Refining, defining and naming themes	This stage consisted of fine-tuning the analysis and initial findings. (see Appendix L) During the interview, each participant consented to be invited to an optional feedback session where initial themes were shared to corroborate the researcher's interpretation of the data. Two sessions were facilitated, where the researcher shared the initial findings, and through discussion, further refinements and clarifications were made. This session supported the researcher's interpretation and refinement of the themes and the overall narrative and ensured it accurately represented participants' experiences. Finally, each theme was reviewed to ensure they were associated with a clear and concise essence or definition. The researcher also made sure they had a solid understanding of what each theme represented in describing the overall narrative of the data. See Appendix M for final dynamic map.
Writing the report	The final stage of analysis involved weaving together the themes and analytical narrative with data extracts and quotes from the data. The process of writing up aimed to produce a coherent story that accurately reflected the data and addressed the research questions

Quality Assurance

To ensure methodological rigour, the researcher adopted Yardley's (2000) framework for evaluating the quality and validity of qualitative research, applying these principles across the design, analysis, and interpretation stages, which is presented in Table 5. A critical appraisal, using the CASP (2018), was also conducted for the current study, which was viewed to meet each of the 10 criteria (see Appendix N).

Table 5

Quality assurance using Yardley (2000) criteria

Quality criteria	**Evidence in support of meeting the criteria**
Sensitivity to Context	To maintain sensitivity to context, the researcher provided a detailed historical and contextual background within which the study took place, acknowledging the socio-political factors that shape the current study. The researcher also conducted a thorough review of the existing literature to ensure sensitivity towards the already existing knowledge and literature regarding the topic area. The researcher also continuously reflected on their influence within the research process using a reflexive diary, paying particular attention to the interplay between the interviewer, who is often considered to have expert knowledge from a theoretical perspective, and the interviewee as the experiential expert (Smith, Flowers & Larkin, 2009). Additionally, the inclusion of a positionality statement enhanced sensitivity to the entire process.
Commitment and Rigour	Following Yardley's guidance, the researcher placed great focus on the development of rapport with participants, including prior to and after the interviews. This included ensuring participants had opportunities to ask questions and that they felt heard and listened too. The researcher demonstrated strong engagement with the data by independently conducting all stages of the study, including data collection, analysis, and interpretation. Transcribing the interviews personally further deepened their familiarity with the dataset and reinforced analytical rigour. Ongoing discussions with academic supervisors and corroboration of findings also supported the integrity of the process.
Transparency and Coherence	Transparency was achieved by openly detailing each step of the research process and maintaining reflexive awareness of how the researcher's background and assumptions may have shaped the study, which are embedded throughout the thesis. Each stage of

	the research was also documented. Feedback sessions, where initial themes were shared with participants in attendance, were conducted to confirm if the researcher’s interpretation of the analytical narrative that emerged through the data analysis made sense and accurately represented the data.
Impact and Importance	Yardley (2000) emphasises value in conducting research that leads to meaningful outcomes. This study aims to understand professionals’ experiences and perspectives of suicidality in clinical practice as it presents for individuals with LD. It provides in-depth insights into understandings of suicidality for individuals with LD, alongside the experience of staff in assessing and managing the risk in clinical practice. It is anticipated that the findings will increase awareness of recognising suicidality in the LD population, which could have a significant impact on outcomes and experience of care. The findings could also support developments towards more effective ways of working with suicidality and identify factors to consider when working with individuals with LD presenting with suicidality.

Dissemination

Findings of the current research project are expected to have implications for clinical practice and support working with individuals with LD. Findings are expected to be disseminated to the participating LD services at their business meeting and/or CPD sessions, alongside a conference held by the DCP Faculty for People with Intellectual Disabilities. The research is also expected to be written up for publication in a suitable journal, for example, JARID or Tizard LD Review.

Chapter Four: Findings

Chapter overview

This chapter aims to present the findings of the current study. Demographic information for each of the participants will be provided, including job role, age category, ethnicity and length of time worked in LD services at the time of the interview. The analysis focused on how suicidality presents in clinical practice and the perceived function it may serve, as understood and experienced by professionals working in the Community LD service. While suicidality was often not identified as the most prevalent concern within LD services, it was consistently described as complex and multifaceted. Two overarching themes, five core themes and four subthemes were identified, each offering insight into how suicidality is understood and managed in these settings. The themes will be presented and discussed alongside quotes from various participants.

Participant Demographics

Fourteen professionals from an NHS Community LD service participated in the study. The interviews lasted between 42 to 88 minutes, totalling 15.27 hours of interview data. Four more people expressed an interest in taking part but did not arrange an interview. One was due to sickness and being unable to rearrange a suitable time on their return, and the other three did not respond following their initial expressions of interest. A summary of the key demographic information is presented in Table 6.

Table 6

Participant Demographics

Participant	Role	Ethnicity	Length of time working in LD services (in years)
Lucy	Nurse	White British	29
Sarah	Art Therapist	White British	7
Kate	Clinical Psychologist	White British	5
John	Psychiatrist	Did not disclose	24
Paul	Nurse	White British	20
Rachel	Trainee Clinical Psychologist	White British	0.25
Amy	Clinical Psychologist	White British	1.25
Olivia	Occupational Therapist	White British	3
Grace	Nurse	White British	15
Jenny	Clinical Psychologist	White British	7
Susan	Nurse	White British	25
Kerry	Nurse	White British	20
Jack	Trainee Clinical Psychologist	White Irish	18
Beth	Nurse	White British	15

Note. The length of service is the overall length of time working with participants with LD. It includes time spent working in other LD services and roles, and is not necessarily the time spent in the LD community service involved in the research.

The 14 participants were employed in various roles across the LD service, including psychiatrist (N=1), Clinical Psychologist (N=3), Art Therapist (N=1), Trainee Clinical Psychologist (N=2), Community LD Nurse (including one nursing manager) (N=6), and Occupational Therapist (N=1). Most participants were female (N=10), with the majority identifying as White British (N=12). One participant identified as White Irish, while one did not disclose their ethnicity. The age of participants ranged from 28-60. The length of time participants worked in LD services varied considerably across the participants, ranging from eight months to over 20 years. The average length of time working with individuals with LD was 13.5 years.

Reflexive Thematic Analysis Findings

Two overarching themes, five main themes and four sub-themes were generated following the analysis (see Table 7).

Table 7

Overview of themes

Overarching theme:	Main Theme	Sub-theme
Understanding suicidality in the context of LD services	The nature and prevalence of suicidality in LD services: not the main concern but often the most complex	
	Making sense of suicidality for individuals with LD.	Vulnerabilities for potential suicidality: a lifetime of adversity and not fitting in Suicidality as a form of communication; a source of seeking connection and containment
Working with suicidality in LD services	Determining the risk and having the difficult conversations; Navigating capacity, understanding and communication.	
	The weight of working with suicidality	The weight of caring The weight of professional responsibility and the limitations of the system
	The importance of working together: sharing the load and not working alone with risk	

Overarching Theme: Understanding suicidality in the context of LD services

Each participant was invited to consider their understanding of suicidality as it presents for individuals with LD. This overarching theme captures participants' perspectives on the nature of suicidality and how it presents in clinical practice. It speaks to the prevalence of suicidality and explores the types of cases that professionals frequently see presenting with these concerns. Within this overarching theme, there were two themes created: *The nature and prevalence of suicidality in LD services; not the main concern, but often the most complex* and *Making sense of suicidality for individuals with LD* which has two sub-themes *Vulnerabilities for potential suicidality: a lifetime of adversity and not fitting in* and *Suicidality as a form of communication: a source of seeking connection and containment.*

Theme: The nature and prevalence of suicidality within LD services: Not the most common concern, but often the most complex.

Participants described encountering various aspects of suicide related difficulties that stretched across the continuum of suicidality, from self-harm to suicide attempt. However, in the context of the wide variety of difficulties that individuals present with, participants noted that suicidality was not always the main concern bringing individuals into contact with the service. Participants described suicidality to be a smaller proportion of their overall work, although referred to it as feeling like a bigger part, highlighting the complexity that is often associated with it:

> *"....when I think about it....like the amount of people I've worked with that have these kind of these behaviours, or these needs, it feels quite big but then if you put it in the context of the amount of people I've worked with over the last 15 years.....they have been a much smaller number." (Kerry)*

While two participants reflected on their knowledge of two clients with LD dying by suicide on inpatient wards, none of the participants reported experiencing a death by suicide directly in the LD community service. Professionals indicated that suicidal ideation and thoughts were the facet of suicidality that they worked most with in clinical practice, which was the most common aspect of suicidality referred to across the interviews. Participants emphasised that working with clients who were actively suicidal was infrequent, with the risk of completing suicide not always being present for individuals with LD. Paul reflected that "I would say the actual people who are actually actively suicidal or at high risk of suicidality, it is very minimal experience but does happen" echoing a common narrative amongst professionals that individuals with LD frequently expressed suicidal ideas, but that it rarely escalated further than this:

> *"My every day [experience]…..it's quite limited, and in my whole years of doing it, I've never actually….I'm sure there are people out there, but I've never actually known any of my clients or wider clients, you know, that have actually committed suicide. I have had a few say, you know, 'oh, I feel like dying, I feel like killing myself, but when you actually speak to them, they've got no real way of actually, no idea of how they would actually kill themselves" (Grace)*

> *"At the moment I work less with it in the sense of like no one's kind of actively trying to end their life, but kind of working with somebody with a learning disability who expresses that she gets dark thoughts and there's definitely a lot of risk there with regards to, like I mean, she has kind of plans, she has the means, but there's just something stopping her going ahead, which is nicer for me" (Amy).*

Nevertheless, all participants acknowledged that it could and does happen, with one participant, Olivia, sharing her experience of a client who did make a serious suicide attempt, resulting in them being held under the Mental Health Act:

> *"So with my second service user who was under the LD team and has been for quite a while because of the extensive history of mental health difficulties. So this service user actually attempted to commit suicide in late August….they were found by a member of the public, sort of foaming at the mouth…..so they tried a ligature around their neck...and as a result, they were sectioned" (Olivia)*

Furthermore, many professionals spoke about noticing an increasing trend in the prevalence of suicidality-related difficulties they encountered in clinical practice. Participants, like Lucy, noted this to be due to an increase in awareness of and openness to speaking about mental health difficulties within this population:

> *"I think it's becoming more frequent [....], you know there's more clients and I don't know why that is really.....whether that's people are more able to talk about their mental health now.....It's all in the, you know, people are aware of it, people talk about it more rather than hiding things....." (Lucy)*

While Susan considered this increase to be a consequence of the deinstitutionalisation movement towards community care for individuals with LD, where the closure of large institutions and hospitals resulted in community teams managing more complex cases:

> *"when I first started in nursing, which would have been 25 years ago or something like that, we didn't really have too many people that were expressing suicide.....the risks in terms of behaviours that challenge is much more now because like when I first started [.....] they [named hospital] were all still open, and so those more complex people, with challenging behaviour or mental health problems, were in those units still...now those people are in the community" (Susan)*

With regards to the nature of suicidality, participants expressed that they felt it tends to be more 'lower-level' for individuals with LD, and presents as a more chronic and long-term difficulty rather than an acute response, as illustrated by Kate:

> *"subjectively, I've noticed it tends to be long term, so if the suicide ideation is there....personally, I've noticed it seems to be lower level but longer lasting rather than like an acute, you know, sudden suicidal thought because of a life event....it just tends to bubble on the surface for a long time, like several years"*

In addition, suicidality was frequently referred to as something only those with mild cognitive and intellectual difficulties experienced, with one participant, Paul, describing it as “a function of a more functioning mind”. There was an overwhelming thread across the interviews where suicidality was generally only considered a difficulty experienced by those who have a mild to moderate LD rather than a severe LD:

> *“think we encounter it more commonly in the mild to moderate individuals, just bordering in the moderate….otherwise in the moderate to severe population it tends to be more self-harming that, rather than actually sort of suicidal ideation or expressions of suicidal intent or ideation that you get” (John)*

One participant queried whether those with moderate LD could be experiencing suicidality, but reflected on the challenges around establishing this due to difficulties with communication and articulation of thoughts:

> *“I've had clients that have said that…yeah, the less able clients we have…..who aren't able to express themselves as much then….obviously we don't know how they're feeling, and they could be feeling like that, but we have no idea unless things come out in people's behaviour…ummm that's the way they communicate….we don't always know…..So it's it tends to be the more able clients that we've got, that they would be the ones expressing it” (Lucy)*

Other participants reported that they did not consider suicidality to be the function behind self-injurious behaviours in clients with more severe LD. Staff intrinsically considered alternative explanations for this behaviour, including understanding it as a sensory-related issue rather than associating it with suicidality:

> *“When people have engaged in those kind of behaviours [self-harm/self-injurious behaviours], when they have, kind of a more severe LD, I've never considered it*

> *suicidality….and I've always looked at alternative explanations, but when someone has a mild to moderate LD, my mind goes to suicidality and I'm not actually sure why that is….[….]. Yeah, cause I think if someone was to ask me, I would say that no one who I've worked with that has a severe LD has ever expressed suicidality…..but like that man, maybe he was, and we've gone, 'Oh, it's sensory'." (Amy)*

Furthermore, many participants shared that suicidality often presented for individuals who had or met the criteria for other diagnoses alongside their LD. Participants reported that suicidality could be associated with mental health conditions like depression, but most often presented within the context of more complex diagnoses such as Personality Disorder (PD) and/or neurodiversity, emphasising again the complex and intersecting nature of suicidality presenting in LD services:

> *"we found at least I've had among the patients that have presented with suicidal thoughts or suicidal gestures, there's interestingly been a significant subset to have emotionally unstable personality disorder…..yeah, and so in that dimension they also have….sort of category of being on the neurodevelopmental sort of spectrum, with Autism Spectrum disorder presentations." (John)*

Theme: Making sense of suicidality for individuals with LD.

This central theme emerged from participants' understanding of suicidality across the LD population, including the factors that they felt contributed to their client's experience of suicidality and how staff comprehend how it presents in clinical practice. There was an overwhelming consensus that individuals with LD experienced a high volume of adversities over the course of their lifespan, which professionals felt contributed to their clients' experiences of suicidality. Participants' perspectives on various factors that make an individual more vulnerable to experience suicidality and its relative functions are reflected in the subthemes '*Vulnerabilities for potential suicidality: A lifetime of adversity and not fitting in'* and *'Suicidality as a source of communication: seeking connection and containment'*

Subtheme: Vulnerabilities for potential suicidality: a lifetime of adversity and not fitting in

This theme encapsulates the wealth of adversities and traumas that many individuals with LD have been exposed to throughout their life, which professionals felt were linked to their experiences of suicidality:

> *"Her's is clearly linked to a trauma that happened when she was in her late sort of teenage [years]. It [expressions of suicidality] tends to be all mostly about that. I mean, she's had other traumas as well, so I'm sure they will kind of link in in some way, but she'd often sort of make links with that one in particular" (Sarah)*

Participants referred to adversities such as childhood sexual and physical abuse, neglect, domestic violence and bullying, as being foundational to their clients' difficulties, understanding the impact of them to infiltrate each stage of life, further increasing difficulties and their vulnerability to suicidality in adulthood:

> *"like I've worked with a lot of people who've experienced many kinds of abuse, childhood sexual abuse or domestic violence when they were a child, and it, and it's kind of mixed into each phase of their life.....their difficulty and their learning disability, so their difficulty dealing with the things in life and changes in life, in each phase of life, that creates its own difficulty" (Jack)*

Other participants reflected on the high prevalence of experiences of ridicule and stigma that individuals with LD are exposed to, which may contribute to low self-esteem and emotional difficulties:

> *"I think just like in the general population, with perhaps more so in our population, the experiences of stigma, ridicule views are probably more common….yeah….so all those negative life experiences, are more likely to contribute to sort of feeling low self-esteem, low self-confidence, sort of experiencing emotional crises."(John)*

> Professionals also spoke about the impact of some of these early life adversities with regard to individuals feeling like they do not fit in or that they don't belong, which were attributed to difficulties with attachments and experiences of feeling abandoned and rejected that were thought to increase the likelihood of feeling unsafe, insecure and experiencing suicidality:

> *"Yeah, I think what most of them have in common is that all experienced, some form of kind of abandonment…they'd all felt abandonment, kind of at several points in their lives….or felt like someone wasn't there to kind of keep them secure and safe." (Amy)*

> *"I think it is often, you know, the idea of not fitting in and not belonging. I guess I've always sort of linked it to attachment. This person had a really difficult start in life due to sort of neglect and abuse and then it was in multiple foster sort of situations and then finally adopted but I guess like thinking about attachment, I think quite often they can feel quite rejected…." (Jenny)*

Expanding on this, participants considered wider existential tensions and societal factors that the LD population regularly faced, which professionals felt contributed to their experiences of suicidality. These tensions referred to a general sense of being marginalised and excluded from society, which was particularly evident through participants' acknowledgement of how disempowering and alienating the world can feel for individuals with LD. More explicitly, participants reflected on how individuals with LD struggled with initiating and maintaining intimate relationships and were frequently excluded from employment opportunities and opportunities for meaningful activities; all of which can further instigate a sense of disconnection, rejection and lack of purpose and belonging:

> *"Yeah, yeah, I think that maybe loneliness, isolation…a sort of lack of, meaningful employment, lack of meaningful day and recreational activities…..all those are key factors and sometimes it's also this ability to sustain peer relationships and sort of not be able to sort of have a feeling that they've sort of not, they don't have a good network of peers or didn't good network of friends and all that sort of has a significant impact I think in terms of the for feelings of loneliness, isolation, abandonment, rejection." (John)*

> *"You know, even I guess like you know during like the COVID-19 pandemic, you know, they weren't sort of thought about as highly as you know, I guess some other members of the population and even sort of, you know, like getting a job or a partner or anything, you know, being involved and feeling important that can sometimes not feel the same, so I think it's no wonder that people feel rejected and alone and isolated and isolated, really isolated." (Jenny)*

> *"I just wonder if it's like a like, yeah, just complete frustration with the world around them…not fitting in….and those messages get internalised I think a lot. And so like, if people are always telling you and can't do something, then you begin to believe, oh, I can't do it…" (Rachel)*

Building on this thread, John and Kate emphasised individuals' awareness of these limitations as a key factor in individuals experiences of suicidality, where differences between typical and atypical development for an individual with LD and the general population may become more pronounced, prompting feelings of being left out or different:

> *"the sort of awareness of the limitations when you sort of progress to adulthood in terms of how the person sort of evaluates themselves in comparison to peers in the general population, can also be a sort of critical factor." (John)*

> *"I think often it's loneliness, so I certainly notice that a lot of people aren't in relationships like romantic relationships. Boyfriend. Girlfriend, what have you….and they want that….so I've certainly had a lot of clients…maybe the slightly older ones like 30-40 who have never been able to have a romantic relationship and that's a big factor for them, you know, they they want to have a lifelong partner, company…and I guess likewise they they might see their siblings or their cousins who might not have LD, might not have autism what have you, and they they might be getting married, having careers, having children… I don't know…moving to a different country or doing all this exciting stuff…..And then some people with LD might feel like left behind or like they can't do the same things as their peers and often find that's a big factor for feeling sort of suicidal and those kind of things." (Kate)*

The idea of being a burden also featured across the interviews in various ways. Some participants, like Rachel, reported that an individual she worked with who was experiencing suicidality explicated stated that she felt that the input she required from others due to her LD, mental health and physical health was too much and that her loved one would be better off if they did not have to do it:

> *"she often talks about being a burden to her mum…she has a lot of physical health appointments as well as mental health appointments within the LD team….and yeah, like not feeling independent from her mum…..and she will say, 'oh, my mum's getting older, you know, I am a burden…..she would be better off if she didn't have to look after me….that she didn't have me to to deal with, you know….[…]. So for that person*

> *is always the burden in a way from very young age, no matter. Yeah. How hard a person tries not to have that message, when somebody has additional needs, I think it's very easy then to kind of for that person to feel like the burden, to feel different, to not have the belonging." (Rachel)*

However, other participants, like Jack, argued against the idea that an individual with LD would feel like a burden and felt that suicidality experiences were predominantly a product of chronic isolation and exclusion from society:

> *"they haven't got enough, they haven't got, they haven't been able to go and do the things they want to do with their life, that they're able to do. They haven't been able to get a job even though they could. They've maybe their experience is more about being excluded and being isolated and forgotten than it is being a burden" (Jack)*

Furthermore, another participant did not consider being a burden in the context of suicidality for individuals with LD and highlighted that for them, this appeared to be a difference between the LD and non-LD population, where understanding the concept of being a burden for individuals with an LD would be difficult and thereby, not something they experience:

> *"I've experienced a lot in non-LD populations, people telling me that they feel like a burden. But I've never actually…I don't….I can't remember ever kind of speaking to somebody with a learning disability about feeling like a burden….that's expressing suicidality. There's definitely people that have told me they feel like a burden…but they're not the people that have expressed suicidal thoughts….So I wonder whether, yeah, maybe if it is different in LD or whether it is a communication thing…..I mean, burden's quite a hard concept to kind of understand and communicate." (Amy)*

Subtheme: Suicidality as a form of communication: a source of seeking connection and containment.

A second sub-theme, “Suicidality as a form of communication: a source of seeking connection, and containment”, was developed, reflecting the dominant perspective that suicidal behaviour in individuals with LD often functions as a form of non-verbal or symbolic communication of needs, rather than being rooted in a desire or intention to die. Participants frequently described suicidal expressions as a cry for help or an appeal for support, understanding it to be a direct communication of their emotional experience:

> *“But that [suicide note] was that service user reaching out and that was what we [the team] felt was a cry for help…..’You know I've been feeling gradually lower and lower’….. and then that resulted in that suicide note” (Olivia)*

> *“it's a cry for help, isn't it, really?.....because if you’re going to do it, you're going to do it regardless of what anyone says……and would you actually tell anybody that….. it seems to be that it's more with our clients that they tell you because they want you to help them, or they think that you can do something to help them” (Lucy)*

Participants highlighted that many individuals experienced heightened emotional pain and distress, which they often struggled to articulate, process or manage, resulting in behaviours that appeared suicidal but were motivated by a desire to end emotional suffering, rather than an intent to die:

> *“She often sort of reports and will say that she just felt really out of control and overwhelmed. We tried to look at what happened before that. If you see what I mean, if she can identify that that there was a row or someone said something to her in the street or that she can often identify a trigger, she's reasonably insightful in that way. But yeah, I think it's the flooding and the IT just becomes too much.” (Susan)*

> *"an intolerance sort of feeling of you know, negative feelings, if they can't cope with feeling upset or worried or angry or, you know, whatever negative emotion or even, you know, some that can't cope with positive emotions and, you know, feeling excited or other things like that, if they can't cope with that emotion then more likely to react to stop it." (Kerry)*

Other participants referred to suicidality as a consequence of their clients under resource and having reduced ability to manage difficult emotions and experiences linked to their experiences of trauma and adversities:

> *"I'd say primarily they're the ones that have had more difficulty with emotional dysregulation and their emotional wellbeing fluctuates have had quite complex early trauma histories […]more of, I suppose, an emotional, emotional release….lots of patients with quite complex histories and traumatic upbringing….so I kind of always associated the self-harm with the trauma" (Kerry).*

> *"….because he's got so many thoughts in his head, he doesn't know what else to do, but he really just doesn't want them, he can't cope with them and he thinks the only way out is to commit suicide. But when you talk through with him, he hasn't got any plans or hasn't as yet made any, it's almost like he just doesn't know what else to do." (Lucy)*

According to some participants, there was evidence that suicidality had become a learned pattern of interaction; a relational style that aimed to seek connection, support, or contact. Although some participants used the term, the majority of professionals were careful to reframe or avoid the language of "attention-seeking," instead contextualising the behaviour as a relational strategy that developed over time to get their needs met. Professionals identified this pattern of attachment seeking behaviours in response to heightened loneliness or perceived lack of social connection and relationships in their client's personal life. Rather than an intent to die, suicidal expressions were viewed as a way to elicit care, gain contact, or establish connections or attachments with trusted staff:

> *"you'll have people who kind of express it because they know it's a way to get connections and they know it's a way to get heard because they struggle to get heard so often in life as a whole." (Paul)*
>
> *"she literally lived just over from [service site] and she was very lonely and she'd been with us for donkeys years, since I think she's been with the team since it had ever opened…she's passed away now, bless her, she passed away last year but I think she learned, she would call up and want to chat but she wanted someone to come round. She learned if she said…'oh you know I I don't want to be here anymore. I feel like killing myself….she knew that nine times out of ten someone would pop over and see her." (Grace)*
>
> *"And they've learned that by saying that's quite a strong thing to say, isn't that you want to end your life? There's probably not much, not anything else that's really stronger than that and they've learnt that that gets that, gets them not attention because that's what I think that's the wrong way to use. But it gets like some sort of connection or someone to come round and see them. And yeah, I think loneliness definitely" (Grace)*
>
> *"they're there constant, like running away, threatening to jump off bridges harming themselves, you know, because….they don't know what else to do…..they know this works to get people around them" (Paul)*

> *"And if someone is getting kind of a bit more connection and the only way someone knows how to get connection is doing something quite risky, then that's, that's what they're going to use" (Amy)*

Furthermore, participants highlighted how their clients often lacked large natural support networks and that professionals were often considered to be core people in their clients' circle of care, with services often providing the sole source of emotional support or connection for many individuals with LD. Professionals reflected that this was often due to difficulties with interpersonal relationships subsequent to limited social relationships or a breakdown in relationships with family, which could result in the service tending to fill those roles that family or close friends might typically hold for the general population. Professionals reported that this placed a great deal of emotional significance on the professional relationship, where disruptions to this support could be profoundly destabilising and increase presentations of suicidality:

> *"they're definitely lonely and that they just want somebody and then they almost become fixated on us as professionals. And also with our clients, we're always saying that they suffer so much loss because staff come and staff go and the same with us, you know,….we work in episodes, so we're supposed to, you know, do a set piece of work and then discharge somebody and we might be the only person that they see frequency…..so that's another loss for them…..and you think about grief and loss, it's huge for the people we work with." (Lucy)*

> *"gain that rapport and then you realise that you're creating a dependence, so you sort of try and pull back a little bit, then that's really quite damaging for that person, isn't it? Because they like wish where they're going do you know what I mean? You know*

> *why they pull him back? What have I done? And you know, through all through all reassurance in the world that you know you this is nothing to do with them" (Beth)*

The function of suicidality in terms of increasing the need for connection, company and interaction was described both positively, as a form of emotional containment and connection, and cautiously, in terms of a fear of creating a dependency on the service's support and care. Professionals spoke about feeling as though the service gets caught in a reactive and responsive cycle of reactive support and care, which many staff worried may reinforce or escalate presentations to get their needs met:

> *"it becomes a bit of a co-dependent thing, and I think that there is room to have that discussion that we need to be quite careful about how we actually reinforce a lot of these [suicidal presentations]" (Paul)*

> *"It's almost like you become a constant, don't you? For a certain period of time and yeah, yeah, and it, but it's really important to try to plan when you start working with somebody, how you're going to finish, which sounds crazy but and with some people we don't do that and then we get stuck…like, how are we going to, you know, how do we get out of this? How do we because we could just keep going and going doing the same thing every week, every month, forever. But we're not allowed to work like that which for some clients that's all they need is just once a month a check in how you're doing everything all right" (Lucy)*

This reflection from Lucy also emphasises the importance of having a proactive approach towards managing suicidality in clinical practice and preventing escalations of presentations. Lucy termed this 'a soft touch' approach, providing a check-in type support aimed at minimising the reliance on the service while ensuring the individual felt supported and thought of.

Some participants reflected on the potential for suicidal expressions to get dismissed in the LD population, particularly if suicidal expressions become a regular method of communicating distress or desire for connection that is never associated with any high-risk suicidal acts:

> *"to say she cried wolf is probably too harsh, but it's her way of communicating she's had enough, but her parents got to the point where, like look, you've threatened to commit suicide five times today….we don't want to know." (Lucy)*

Participants also highlighted the risk of presentations escalating if the factors and needs that underpin suicidality-related behaviours are not met. Paul shared his experience of a client who frequently presented with suicidality escalating to knife crime to communicate his needs further:

> "….[he was] *habitually suicidal and then escalated to actually knife crime to try and get a response 'cause that worked once if I I took a knife out and I threatened someone with a knife that worked….ended up getting remanded." (Paul)*

He also spoke about this in the context of individuals receiving inconsistent responses from services, which may further increase suicidal behaviours to elicit a response:

> *"they get a lot from us and they get nothing from them [MH services] and then that can cause so much anxiety…..and emmm…and that is gonna keep reinforcing them doing what the only thing that works that gets people to listen to them, which is yeah, frightening." (Paul)*

Overarching Theme: Working with Suicidality in LD Services

All participants were asked questions about working with suicidality in LD populations. The overarching theme: 'Working with suicidality in LD services' encapsulates professionals' experiences of working with it as it presents in clinical practice. It also highlights some of the challenges and impact of this aspect of their work. It incorporates three main themes ‘Determining the risk and having the difficult conversations; Navigating capacity, understanding, and communication’, ‘The weight of working with suicidality which has two sub-themes ‘The weight of caring’ and ‘The weight if professional responsibility and the limitations of the system’ and the final theme ‘The importance of working together; sharing the load and not working alone with risk’.

Theme: Determining risk and asking the difficult questions: Navigating capacity, understanding, and communication

This theme reflects participants' experiences of determining the level of suicidality-related risk with individuals with LD. All participants spoke about the various ways that they uncovered their clients were experiencing suicidality. Participants reported that conducting a standardised risk assessment, including suicidality, was routine practice at the intake stage to the service or on allocation to a named clinician. Some participants shared that this was usually reviewed in appointments if the individual was seen by the psychiatry team, however, the majority of individuals reported that screening for suicide risk was not something they did as standard practice when working with individuals with LD, with many indicating that they only tended to explore suicidality when it was warranted and necessary with individuals needing to be explicating showing potential signs of low mood, depression or declining mental health:

> *“if I went to see someone and you know, they they weren't presenting with those risk behaviours or they they weren't kind of showing the signs of emotional stress or there wasn't any indication of a history of risk. I maybe wouldn't necessarily ask if they were having thoughts of kind of hurting themselves as a standard.” (Kerry)*

> *“It depends if the person has mental health problems on top of them, we would ask them, and psychiatry tend to ask in all of their clinical [appointments], which we support with any way. But yeah, we would ask if we felt somebody was perhaps leaning that way, but it isn't something that we routinely would ask people, unless we thought that, you know, there might be that feeling” (Lucy)*

Other participants mentioned that it would be something that they would hold in mind and that it may naturally come up due to their role. However, similar to other participants, they would not necessarily ask directly unless it was indicated:

> *“So part of that is looking at mood and motivation, patterns of behaviour, their roles, their responsibilities….so I think those sorts of topics come up quite a lot in my assessments and my intervention, but when it gets to the point that someone's, that we'd seen such a deterioration in his engagement that we would then starting to kind of ask some of those questions because we were naturally worried about how withdrawn he'd become……so they are routine stuff that we'd look at, but not necessarily ask those questions unless it was indicated” (Olivia)*

Another participant mentioned that they would ask in their assessment and regularly speak about it during sessions. This highlights a potential inconsistency across the various professions in the service whereby asking about suicide is dependent on the clinician and not standardised practice:

> *“I think I probably do ask quite a lot. Yeah, I think it would be part of my assessment. I would always ask and I guess for her, it was regularly spoken about.” (Jenny)*

There was a strong consensus across participants that suicidality-related risk needed to be broached with sensitivity and could rarely be comprehensively determined without the establishment of a strong relationship and building of rapport. Staff repeatedly noted that individuals with LD were generally open to discussing suicidal thoughts, and often brought these concerns up themselves. However, the majority of professionals felt that such disclosures usually occurred once rapport had been established:

> "*don't think there's a marked reluctance or a sensitivity once it's broached sensitively for them to sort of get involved in the discussion and sort of mention it and then discuss it further." (John)*

> *"To be honest, they normally just people normally just say it emm just outright, but not necessarily at the beginning, so people might not be saying it during my assessment or like initial assessments initial assessments sorry, but maybe like when we're in the throws of therapy and you know the rapport is there, people are more like just to say it in just general conversation…" (Kate)*

> *"he was quite open with carers, and myself so it was easy to open up those conversations because I had that rapport." (Olivia)*

Expanding on the importance of having a strong professional relationship with the individual, many professionals also emphasised that the level of risk was more easily determined once a good rapport had been established. Staff spoke about the value of knowing the individual well and being familiar with their presentation and struggles, which aided them to make a decision about the level of inferred risk that was present. Participants, like Jack, spoke about it being more difficult to fully determine the level of risk, which required more consideration when they did not know the person well:

> *"I would say that's more difficult when you don't know the person….cause you can't….if I've worked with a person for several years, then I know the protective factors, I know the stresses, I know the patterns…..I know what things are relevant and what we can, what options there are. But if you don't know someone, you're*

> *relying on someone else to know the bits that are relevant or not….you ask the best questions you can and listen really carefully" (Jack)*

On a similar thread, other participants reported being able to intrinsically interpret what individuals meant when they shared difficulties or expressions of distress and suicidality. More explicitly, they highlighted that knowing the client well could facilitate interpretations of presentations and help staff better gauge the meaning behind the individual's presentation. Amy spoke about being able to instinctively infer what her clients meant when they reported that they were having a bad day and whether this meant that risk had increased or not, which would not be possible without a good rapport:

> *"the more you get to know certain people, they would kind of tell you, like…."I'm having a really bad day"….and you knew what that meant….but you had to, kind of, build up that relationship with them for quite some time for them to openly tell you" (Amy)*

A significant challenge in determining the level of risk lay in establishing whether individuals understood the concept of suicide and its consequences, and whether their actions or expressions reflected true suicidal intent. Some professionals were confident that some individuals with mild LD have a good understanding of suicide and have the capability to consider suicide:

> *"I think the majority of people who with mild learning disabilities in our population, they have an understanding of those concepts, they have an understanding of what, of what the concept of suicide is what the concept of suicidal sort of attempts are" (John)*

But that those with moderate to severe LD struggle to comprehend the concept:

> *"I think in that population group [moderate-severe LD], I think a significant proportion may not have a good sort of concept of those, I mean, I mean a good understanding of those concepts. So in that population group, I think it's an issue which we have to sort of explore with a lot of depth and with a lot of sensitivity, but and sometimes they are genuine difficulties and sort of understanding, and then in probably the conceptualization of those sort of concepts." (John)*

For many individuals, understanding and determining comprehension and intent was ambiguous and unclear, posing a challenge to determining the true extent of the risk. Staff reflected on suicidality being a complex concept to understand and queried whether their clients fully understood the risks and finality of death. Professionals reported that they frequently encountered individuals expressing suicidal ideations but on further exploration, they either had no intent to die, or did not have a comprehensive plan that would likely result in completed suicide:

> *"But on further exploration, there was no kind of suicidal plan…..there was kind of ideation, but there was no set plan, so I when asked some really difficult questions [….]like what was his plan? He would…..he couldn't give an answer" (Olivia)*

> *"I think certainly with the sort of more moderately disabled and not really having the capacity to understand what they're doing..[…]They might understand death in some way, but I mean, how do they understand death is a finality?....It's really hard to communicate these things" (Paul)*

> *"She has a plan to take her medication….How, how? How would you take your medication like to end your life and what?...'I have at least 2 tablets that I take for pain, their paracetamol and I asked a bit more….So how would you? 'I would take*

three' and so kind of like it's not so much capacity, maybe it's understanding….so that provides a little bit more safety, but the message is still the same." (Rachel)

"I've had clients say that they've overdosed on paracetamol or something, but maybe they've only taken like 4 to 6 tablets, which as long as they're healthy, probably isn't going to do them much harm without them realising" (Kate)

"'oh, I'd get one of my knitting needles and I'd just, I'd stab myself with it or something like that' And you're like oh [client], you probably wouldn't, that wouldn't be very successful if you used a knitting needle…oh I wouldn't use a knife….so it's that sort of, I don't think the full understanding of what they're saying is there, but they understand that that gets them, you know the connection that they might need at that time or you know that if they're lonely, someone to pop over." (Grace)

Nevertheless, staff expressed concerns about the risk of accidental or unintended death in individuals with LD due to limited understanding, which many felt could be higher than intended death by suicide for this population. Some participants spoke about worrying that individuals with LD may not understand the consequences of certain behaviours and thereby may unintendedly complete accidental suicide:

"worked with lots of lots of younger patients that would self harm and the risk of kind of accidental, unintended death was always an issue." (Kerry)

"But we also think about safeguarding whether they're able to keep themselves safe at home….so things like accidental deaths, we think a lot about that in LD, accidentally taking too much medication because they don't understand the dosage rather than actually be actively suicidal." (Kate)

"somebody had had tied a ligature and she used to tie a lot of ligatures, but this one….and they felt like she tied them and left an almost gap for them to be able to

> *take it off……but this one was so tight and they felt like it she just accidentally tied this one" (Grace)*

In addition, professionals shared that aspects of the client's cognitive profile and presentation related to their LD and/or autism also influenced the level of risk. Many clinicians felt their clients' concrete and literal thinking styles, impulsivity, and suggestibility could all potentially increase the risk of suicide or unintended death. Participants shared that many of their clients tended to get fixated on ideas, and for some individuals these increased thoughts linked to suicide:

> *"there's other people who've I've worked with who work who've struggled with a low mood and when exploring it, they didn't seem to have thoughts of ending their life but would be very impulsive….they like ran in front of a lorry one day and they were OK and they weren't hit, but it was, yeah, I guess impulsivity…..so the planning didn't seem to be present but yet when the opportunity arose or there's a stress and the need to escape." (Kerry)*

> *"And in this service you know they can go from almost zero to 100 within seconds and very impulsive….so the risk of suicide, you know, even if there's not a plan." (Olivia)*

> *"…if they are presenting with an episode of feeling distressed or low in mood and experiencing suicide ideation, you are much more sort of careful in evaluating all those risks…[…]and particularly if there's this added dimension of neurodevelopmental disorders…..because with autism you can get a sort of fixation on your sort of thoughts and difficulty in shifting from it, so all that adds to the sort of the the evaluation of risk at that point at that time point here" (John)*

Other participants shared their concerns around individuals in this population, being vulnerable to influences from external sources such as the internet or social media, which was viewed as potentially increasing the risk of suicidality, as outlined by Jack:

> *"So I think some people get the idea or the idea from social media, so I work with one person, an autistic person, who was feeling low, but then it was around the time a celebrity, Caroline Flack I think it was, took her own life….and it was all over the news. It was all over like my clients Facebook….people talking about it….and this outpouring of how terrible it is…..but to the point where my client couldn't take their mind off, it was everywhere….they couldn't take their mind off us…..and I think it came out about the method that she used to take her own life….so then that method for this person became they become very fixed on that and that's the way they would do it, even though they didn't know the steps to take"*

Clinicians described an emotional and ethical dilemma when determining suicide risk. There was a strong desire amongst participants to take all expressions of suicidality seriously, as even if the risk of completing suicide was deemed low due to limited understanding, many felt the emotional distress was still there. However, there was also an ongoing concern about whether asking directly about suicide might suggest the idea or reinforce the behaviour and thereby increase the risk further:

> *"it feels kind of a bit scary to have the conversation of what do you think is out there also because nobody knows and if it's a bit scary to go to delve to that because you also, I know it's not meant to trigger anything by talking about suicide, but you do worry a little bit that it got by going into depth are you normalising it a little bit and then it's, you know, it's going to become a more familiar thought to that person then then they might not be so scared about what's after" (Beth)*

> *"like I don't want to talk about it.....if it plants seed in their brains, [...] and I suppose I do have that a little bit....of like I don't want to tell this person that 3 tablets is not going to kill her.....yeah, because I don't want to plant the seed that, oh, she needs more." (Rachel)*

Some also acknowledged their own internalised biases, such as underestimating an individual's capability to complete suicide or viewing them as childlike in nature, which sometimes created discomfort in broaching topics of death or suicide:

> *"suppose I did come work into this with a bias around a person's capacity to even do it, if that makes sense.....and so maybe as well, that's another you know reason behind the disconnect that I can hold that risk is because maybe there is a bias of like 'oh, has the person got the capacity and ability to do it? Umm....yeah, now working with the client I think yes, of course they do" (Rachel)*

> *"the eternal child trap is a big one and we all fall into it, you know, even seasoned professionals who will kind of like. you know, just think they're not taking someone seriously when they're saying, oh, they are acting up the way they would view their teenage child acting up, you know, it's like that is that is still a very real and present problem" (Paul)*

> *"...potentially because he's quite he was quite childlike I guess in his nature.....and you don't want to.....it's hard to think of somebody like that being suicidal.....but it is possible and I literally never thought about it until now" (Amy)*

Amy also reflected on the potential discomfort professionals may experience when asking risk-related questions if the individual presents with a child-like demeanour:

> *"And just thinking about how we actually ask those questions and again, whether we feel comfortable to ask those questions with somebody who we might associate more*

> *kind of childlike and hear a lot of people say, oh, I think about my own children when I think about this adult.....Is that something? Although they're not a child? Is that a conversation you feel comfortable having with someone that you see as a child?" (Amy)*

Participants emphasised the importance of language when determining risk and having the conversation around suicide with this population. Participants advocated for using simple, clear language, avoiding the use of metaphors or ambiguous phrases when engaging in conversations about suicidality, alongside checking out the individual's understanding and determining risk for this population:

> *"So you can sort of discuss those concepts and by simplifying language you can get a sort of understanding of the comprehension of those concept" (John)*

> *"I suppose I'm quite direct…I use, you know, the word 'kill yourself' rather than sort of hurt yourself, rather than trying to use like a metaphor or like a like trying to beat around the bush because I don't think that's very helpful." (Kate)*

> *"I think I would adapt my language, it wouldn't be the same way I would talk about it as an adult service like an adult mainstream mental health service……[…] I think language is definitely a barrier and even like the way you communicate, like not just a language, but sort of like the sentences you're using…and like how complex they might be….And I guess these are stressful conversations and I think when things like this come up, we can sort of think quite quickly and sort of jump around. But you said to sort of slow yourself down and make sure you're really covering all your bases, that they're understanding, that you're checking in, that they are understanding" (Jenny)*

Theme: The weight of working with suicidality

This theme captures participants experiences of the impact of supporting individuals with LD who are presenting with suicidality in clinical practice. Each participant reflected on the various ways that working with suicide related risk has impacted them on an emotional, personal and professional level. It also includes some of the challenges related to providing care and being responsible as a clinician.

Subtheme: The weight of caring

All professionals recognised the emotional impact of working with suicidality, with some professionals, like John, describing it as a '*challenging*' and "*significantly demanding process both for the professionals and for the patient and the family as well".* Others acknowledged that there is a limit to professionals' capacity for care and compassion in their roles. This was reflected by Lucy, who stated that as clinicians, they "*can't keep on taking everybody's emotions"* without consequence. In contrast, others emphasised the struggle of switching off, highlighting that there exists a "*risk of you take [ing] home your worry about them" (Paul).* Similarly, Grace outlined the increased worry that came with working with high-risk cases:

> *"if I were genuinely concerned and worried. Yeah, I'd need to carry that on you, wouldn't you? I'd probably feel a bit nauseous.....and yeah, a lot of worry until I knew they're OK." (Grace*)

Others reflected on the impact of the increased personal and professional demands, particularly when it comes to the time required in comparison to the time available when working on these types of cases. For Sarah, her part-time role appeared to increase anxieties due to her limited time, which may result in an imbalance of the time required and the resources needed to effectively manage high-risk cases:

> *“So it's quite an impact from a personal resources, and work, resources…time…..I'm only two days a week, you know, it can all get a bit fraught, I suppose, which is anxiety provoking, isn't it?” (Sarah)*

Other participants spoke about the heaviness that can be experienced by professionals in trying to support individuals experiencing suicidality to see that not everything is as bad as it seems, as reflected by Jack. He also speaks about the limitations of what you can do as a professional and recognising that it is impossible to do everything:

> *“So you're trying to help them, you know, show that they're not alone, but also that there is other ways of seeing things….and there is, you know, life beyond that dark cloud….. but it, it's a, it weighs heavy as a professional when you're working with someone and you're trying to help them see past that, or help them get through it and yeah…..you know you can't do everything….you can't do everything for everyone or be everything to everyone.” (Jack)*

Others, like Beth, spoke about feeling strained and frustrated at times when working with cases experiencing suicidality, noting that they often take time away from clinicians being able to do other work with other individuals. Beth noted a pressure to have to hide this from clients but had found ways that enabled her to prioritise tasks to complete:

> *“I mean you end up obviously having a higher level of contact with that person than you would with anybody else and then that can create quite a strain because I've realised, you know, yesterday I just had to kind of ignore my phone and like, try and prioritise these people that I've got to do…..it's still important things for like epilepsy plans, things like that they're really important, but they're not getting done because of the high level of risk that you carry with some of the other clients so it can create a bit of frustration sometimes, but obviously you just do what you can….it's not like*

> *obviously you can't let that show because that would just be absolutely terrible because we are probably the one service that they have had listened to them and be there for them."*

For many the emotional impact was further fuelled by the fact that suicidality wasn't something that they encountered with every client so therefore had limited experience to build confidence. Participants, like Olivia, stated that she felt *"out of my comfort zone to be honest, because it was, you know, we were at crisis point with this, with this individual's mental health"* when working with an individual expressing suicidality.

This was in contrast to the few individuals that had previous experience of managing suicidality through various other roles including working on the inpatient ward or other general mental health services, who reported feeling confident discussing and exploring the risk:

> *"think I I do feel fairly confident doing it, but I think that's because my very early experience is being on those units….if I didn't have that…..I don't think I'd feel very confident at all" (Amy)*

Another participant, Rachel, spoke about feeling more desensitised to suicidality as a result of her previous experience of it in another team. Rachel spoke about feeling more comfortable asking about it and being okay about the not always being able to control what an individual does:

> *"the risk of suicide and self-harm was always very high [in my previously role]…and so I always wondered if I have a bit more of a desensitisation to when someone says about self-harm or suicide. I do, you know, we'd have the discussion about it,…but I also don't feel like sometimes I don't worry about it" (Rachel)*

One participant highlighted the potential positive of the team not feeling experienced in navigating suicidality, in terms of still feeling impacted by it, which was considered to mean that individuals tended to support each other better and utilise supervision more about the case:

> *"We haven't become sort of immune to that. It's still like, oh gosh, right. OK, we need to think about this, not they wouldn't. But I think we take it. It's more shocking to us, which might mean that we actually support each other better when we take it to supervision or within our team. We also don't have as much experience and it is. Yes, it's not. It's difficult to come to work and experience things like that or hear bad news or yeah. (Jenny)*

Others spoke about the increased anxiety and worry around the unpredictability of risk and not knowing or having control over what is going to happen. This was particularly evident for clinicians working with clients who were considered to be quite impulsive. For some, this resulted in increased unease and questioning about the service's input and practice. Jenny, reflected that when she is faced with such uncertainty she queried whether as a team they were doing enough:

> *"I guess, like it's it's a worry, isn't it? You never know what's going to happen.....and I guess the impulsivity of this case as well, you know, I don't know what I'm going to come into, or emails, or you know, when her name appears……so I think that could be really difficult. And the case that I've worked with before….again that I had a lot of worry about her and what was going to happen.....were we doing enough?.....Was it the right kind of support?.....So yeah, I think again that was very difficult." (Jenny)*

Nevertheless, even those who reported feeling confident about it now also acknowledged having once experienced worry and concern about suicidality. Amy, reflected on the fear she felt about how quick something can happen and not being able to do anything about it. She spoke about the power of this fear to potentially get in the way of being compassionate towards clients, which, for her, only decreased with exposure and experience:

> *"And how do we stop it? Because in that moment, there was no way of me, me stopping that.....but the more kind of exposed to it I was.....I guess the less scared I became and the more compassionate I became, because I think the fear got in the way of compassion." (Amy)*

Some professionals spoke about some of their traits, such as their caring and empathic nature, that may increase vulnerability to experiencing negative impacts of the weight of caring. Some participants mentioned their reasons for wanting to work in their roles, which included their caring nature and desire to help. Moreover, although participants felt that supporting individuals with experiencing suicidality was an integral and important aspect of their job, many participants reflected on the double edge of empathy and care:

> *"empathy is a double edged sword.....you know, I think as I've always thought about it, in terms of your greater strength is often the greatest weakness…....that's something that I've come to realise, is that I wouldn't change it because then I'd change something quite fundamental about what I do.....but I have been told repeatedly that I've cared too much"(Paul)*

Paul also reflected on the negative impact on his own wellbeing and mental health due to his caring and empathic nature. He shared some important personal realities for professionals working in high-demand caring roles and the potential consequences of care, while acknowledging the value of building emotional resilience:

> *"you're an empathetic person,....and its the reason why you get into this kind of care, but you're going to be a collateral damage…[.....],you want to help them....and when*

> *you can't help them, unless you put up plenty of resilience and shields, which I've had to develop, it didn't come naturally…..then yes, the impact, the emotional impact and the mental health fallout, it can be quite serious." (Paul)*

Some participants spoke about managing suicidality as being part of the job, but recognised the importance of acknowledging that they, as staff, may be impacted by it. Participants, like Kerry, spoke about the value in people having permission to be upset, and being open with how difficult it can be to encounter suicidality and supporting people in distress:

> *"It's it's part of the job, isn't it?....to go out and assess that, it's understandable that you feel upset, you know……I think it's just more promotion maybe of that it is difficult to hear those things, and it's OK if you're upset about it" (Kerry)*

Nevertheless, professionals consistently spoke about setting aside their worries to prioritise the client. There was a strong desire across the interviews towards wanting their clients to know that they cared for them and that they wanted to help, as outlined by Amy:

> *"I have like this overwhelming urge to let them know, like I care….that I'm asking these questions because I care and I want you to be safe and wanting them to know that they're cared about"*

Subtheme: The weight of professional responsibility and the limitations of the system:

In addition to feeling the weight of caring for and supporting an individual experiencing suicidality, many participants reflected on the extra weight and pressure stemming from the organisation and service, alongside the responsibility that comes with being a professional when managing suicidal risk. Some participants, like Grace, spoke about the code of conduct within which nurses work, reflecting the weight of the responsibility professionals can feel towards preventing suicide and death. Grace reflected on the potential pressure of needing to do all she can to prioritise and preserve life, including preventing suicide where possible. She outlined the heaviness and potential emotional impact that she would feel if she did have a client die by suicide:

> *"I think the guilt, I wouldn't be able to work….I'd have to have some time off work. Yeah, because that's our job….you know, we're here to preserve life….the last part of the NMC [Nursing and Midwifery Council] code of contact…..we preserve life and that…..yeah, I would be absolutely devastated if that had happened to one of my patients…distraught" (Grace)*

Other professionals alluded to the negative impact of the bureaucratic nature of the healthcare system and the organisation's policies and procedures in relation to suicide prevention. Some participants found the process of documentation and following the necessary procedures for managing suicidality added stress rather than relieved it. For example, Jack spoke about the added pressure of not only needing to take action and respond to suicidality when it presents, but the additional obligation towards documenting and accurately recording what he had done and considered in line with the organisation's policy regarding suicide prevention. More explicitly, Jack reflected on the pressure of getting this document correct and making sure he had considered a variety of factors within a context where you cannot control what someone does if they are experiencing suicidality:

> *"like, there's the stress of a document as well, where you have to write up and show that you've considered all these things and all these factors and what you write up about it has to be right? Like if something goes wrong you know, like 90% of you is serve nearly 100% of you saying if something goes wrong, you're worried about the person, but then there's this part of you that has to make sure that the document is*

> *right and that like professional bit of you and that's difficult because you can't control what someone does with their life and what's going on in their head and yeah so there's definitely a added stress to that at a time."(Jack)*

Other participants expanded on this, emphasising professionals' fear of being blamed if someone they are working with died by suicide and spoke about feeling worried about what might happen to them or their job:

> *"I think there is a lot of, a lack of confidence from working with suicidality and I don't think it's helped by some of, some of the policies that came in….I think it's really important that we work as a team to kind of reduce that…..but you hear like kind of, the zero tolerance policy and people are like, 'Oh my gosh, I'm going to get punished if this does happen'.*" (Amy)

In addition, participants spoke about the pressure and responsibility of being the main clinician involved with an individual presenting with risk in the context of wider system fears about the process that happens after a death by suicide, highlighting a potential culture of blame that exists in relation to suicide prevention:

> *"…as a professional you can update your risk assessments, you can refer to the right teams, you can do everything you can, but there is still that sense of responsibility when your name is attached to them on Paris [online record system], and there is this as well… I don't know what it is about….you know, you know, colleagues, make some offhand comments…."we don't want to go coroner's court, or you don't want to do this" and…..those negative [comments], you know that fear around that isn't very helpful." (Olivia)*

Participants also spoke about the hierarchical structure of the service and the additional challenges of being in more senior positions. Participants like John spoke about needing to lead the team with risk as other's tended to look to the more senior people to advise them about risk:

> "Y*eah, I guess a lot of people look to the psychiatrist or the consultant in the team to sort of evaluate those risks and to guide the team in that context……[…..], I think sometimes it can be quite, it can be emotionally draining or can be emotionally significant."(John)*

Another participant, Paul, spoke about their experiences of managing other professionals' worries and the wider team's anxieties around risk. He reflected on the challenges of needing to balance his own needs as an individual, alongside supporting the wider team to ensure that the team functions well to provide a good service:

> *"I've learned to bring myself back a little bit there….keep something, keep something back, you know,…..you can still be empathetic, but keep it back….and so the same applies for staff and service users, but you need to have them functioning well to deliver a good service….so you got to put their needs as a priority a lot of the time." (Paul)*

Similarly, Amy reflected on the time spent providing reassurance to colleagues around managing risk which she related to the lack of confidence that exists across the wider team:

> *"….I'm and we're repeating conversations, and I spend a lot of my time going….you know it you've done it, you're doing a good job." (Amy)*

In addition, participants spoke about additional stresses involved with supporting colleagues following a difficult incident and needing to do this while also experiencing the impact of the incident:

> *"Hmmm sometimes it's a psychologist like ourselves that are asked to go and do the debrief for us, we're the ones asked to sort of contain and manage the anxieties and the feelings…..which in itself can be a bit of a heavy thing to carry, I suppose, you're human and you might be likewise anxious or sad, but you've been asked to support the team, nurses and MDT members that can feel a bit heavy sometimes" (Kate)*

Theme: The importance of working together: sharing the load and not working alone with risk

There was an overwhelming consensus across the interviews towards favouring of a team approach over an individual one when managing suicidality-related risk for individuals with LD. The majority of participants spoke about the benefits of involving a variety of professionals and working in a more collaborative way to effectively manage risk. The theme also illustrates the sense of reassurance and safety that professionals felt in the context of their team. It outlines how each of the participants utilises the wider team when working with individuals presenting with suicidality, with team working being highlighted by participants as a crucial part of managing and addressing risk in clinical practice:

> *"I would say there's much more of an emphasis and a need for team working with, with individuals with learning disabilities if you want to really appropriately address those risks and sort of get the best sort of outcomes." (John)*

For some individuals, working systemically and having other members of the team or other professionals involved was particularly helpful when professionals only had limited contact with an individual each week, as outlined by Kate:

> *"for me personally, I do feel better if I share out the risk and have more of a system around the person….particularly, you only see them for an hour a week..[…] If I do think there's a real risk, I always want support from the team, so I don't like to work*

> *alone with risk. So if I thought that someone was in danger of self-harm or suicide, I would always let our psychiatry colleagues know, check who the care coordinator was, make sure they know, maybe get nursing to go in and visit, or call the patient in between psychology sessions so they've got more than an hour a week" (Kate)*

Similarly, involving parents and carers in the conversations and knowing that they have other people around can provide professionals with a sense of comfort:

> *"…knowing that like we're gonna speak to their carers and people like that so we can share these conversations [….], I think sometimes you think, oh, there's other people around which can be quite a comfort as a therapist." (Jenny)*

> *"We certainly think about a lot more about, you know, getting the family involved or the carers involved, like, you know, if someone's said they might cut themselves with their consent, we would talk to the family or the care home about, or supported living home about…emmm hiding the knives, like putting the knives somewhere safe, that sort of thing. (Kate)*

Other participants highlighted the benefit of involving the wider team when making decisions and problem-solving risks and not doing it alone. For some clinicians, working in collaboration and having some backup from colleagues was considered helpful for elevating fear when risk presents. From various accounts, it was highlighted the importance of working together which seemed to be experienced as supportive, provide a sense of containment, advice and support:

> *"If it's just you as a single practitioner, it's quite scary because you feel like you've got to come up with an answer, I would always try to push to involve as many people as possible in the decision" (Paul)*

> *"...we work quite autonomously in community nursing and I think if you're, it's good to have a backup if I'm worried about someone or worried about a situation, I'll always take another nurse with me or another healthcare assistant....and I think it's quite important that you've got like managerial backup as well. For instance, like [lead nurse] at the moment is really, really good...like if you've got a difficult case he will come along to any sort of MDT meeting, he will actually go out and see those patients as well with you.....so yeah, I think sometimes it's having another pair of eyes on things as well that that might change your judgement....or that person might have a different opinion on the matter or just other ideas for instance." (Grace)*

> *"So yeah, I think it's so important that we, we lean on colleagues just to debrief. And again problem solve [....] you know I contact [Named Colleague] quite a lot, our community nurse. He's been great, kind of overseeing some of these cases....and just any little bit of advice on how we can safeguard and protect, particularly after suicide has been has been opened up." (Olivia)*

In addition to having a space to discuss a client and the benefit of looking at a case from different perspectives, the importance of having a good rapport with colleagues and working together cohesively was also emphasised across participants' accounts. Having a team that works well together was seen as helpful for managing anxieties associated with the complexity of the cases that tend to present with suicidality:

> *"I think fortunately I have a good report with all the other doctors in my team and with the other team members [....]. But by being able to discuss it sort of openly with team members and sort of looking at their perceptions, their views sharing the sort of difficulties or the difficult thoughts that they've encountered, it does help you sort of gain a better sort of perspective of the situation, it helps you sort of cope with your*

> *own feelings sort of package them and I think having those, I guess there's good relationships, professional relationships with team members, having a cohesive team….it does help significantly, I think, to help you cope with that burden of trying to sort of address these complex issues." (John)*

Many participants reflected on the value of informal support and reassurance provided by the team through general conversations with one another in the office:

> *"I'm always working with the team as well. There's always like a team, there's always someone in the office that if I really needed to have a chat with, there'd be someone there, you know, which is good." (Sarah)*

> *"And if you're in the office and we had a difficult phone call, people can generally tell. And so, you know, they'll be around you. You'll have to. It's quite nice. You often find that if it's a difficult conversation that someone will, you know, just kind of hover and or you or you call someone over and someone will come and kind of listen in to support you and offer some guidance if they've got any and you know that kind of thing so." (Susan)*

> *"I think definitely the having a supportive wider team helps…you know, being quite a big team and there being lots of people in the in the office…you know, if you come back from a difficult visit and just sit in and having a cup of tea and having a distraction from other people that definitely helps, and you know that this kind of, the wellbeing things, like the caring cuppas and things that it's an, it's an opportunity that you have to use." (Kerry)*

Many participants shared that these informal discussions were the most helpful when facing challenges and difficulties with clients. Some participants spoke about wanting to increase space for these types of discussion and support, as they felt there were often formal debriefs and support offered after an incident, but that there weren't always opportunities for more informal support for everyday challenges of managing high-risk and complex cases:

> *"I think the unless there's a explicit incident, maybe the the support is that you have to go and ask for it rather than or you know if it's a more difficult, not difficult patient. But like the someone that's that's very complex where the risk is very high, even if there's not current incidents. But the risk is high and kind of everyone, not everyone knows, but you know it's been discussed in management meetings so people are aware of, you know, or there's multiple teams involved with the same person. There's more, I suppose, checking in. There's more MD team meetings, there's more, more people involved in not just the risk management, but kind of i can name with each other like. Are we doing? All you know? Are we all doing all right? But yeah, so they maybe the ones where it's just the assessing risk or you know assessing historical risk or being informed of historical risk there's not yeah, unless you unless you go and ask for it, there's there's not much help." (Kerry)*

Other participants highlighted their desire for more informal peer support within the service:

> *"we need to set something up as reflective time come peer support, come, however, we want to word it as an informal thing, but that that time should be put into our week or month or whatever, to have some support because it can be challenging for us as well" (Lucy)*

Building on the thread of valuing team discussions, other clinicians spoke about the value of more formal team meetings with members from the multidisciplinary team, which were perceived as helpful in gaining a deeper understanding of the individual's situation through different perspectives. These professional meetings were also viewed as beneficial in creating a plan that comprehensively addresses all of the issues:

> *"Yeah, I think a good thing is when patients are quite complex, we often tend to have team meetings and professional meetings and we have a good relationship between all the team members, so it's useful to gain each other's perspective. [.....] I think we are able to sort of get a good formulation of what the relevant factors are, discuss what may be contributing the risk and that I think that helps us good get a good sort of cohesive plan together to address all those risk issues." (John)*

Amy shared her experiences of the team coming together to reflect on an incident which facilitated good learning for clinical practice. Her reflections highlighted the importance of having a non-judgmental space to think about difficulties that appeared to increase her confidence as a clinician and influenced how she now provides support to other colleagues:

> *"…the team kind of came around, did a debrief, did some reflection, and we could all just learn from it together. There was not at one point where I felt to blame…and yeah, that then kind of boosted my confidence and I think it helped…..then when people come to me, we just take it on together." (Amy)*

Similarly, other participants also spoke about the value of striving for and providing a culture of reflection within the team, with many participants emphasising the value of supervision for discussing and reflecting on difficult cases. They viewed it as another way to navigate the difficulties that arise while sharing the load and gaining reassurance around navigating risk:

> *"I guess that varies depending on your profession. So obviously in psychology, we do have regular clinical supervision. So I have supervision fortnightly with a consultant*

> *psychologist, someone that I know very well and that's really helpful so I'd always be able to talk to her. So that is helpful sort of mean I'll talk about my own feelings and reactions in supervision" (Kate)*

However, Kate also highlighted potential differences that may exist across the various disciplines in the team, where reflective practice and supervision may not be a priority for all disciplines. Additionally, she also pointed out some wider issues that exist for staff in accessing some support following an incident:

> *"I know, like from a wider service, if there has been an incident that the trust are meant to offer, like debriefing sessions and and staff support. I've not personally needed to access that so far in my career, but I know colleagues that have tried. And unfortunately, it's not always been a quick response, like some of my nursing colleagues have had to wait months even for any sort of response from management or debrief" (Kate)*

Other participants also reflected on the potential challenges that come with teamwork and the importance of everyone contributing and playing their part, so one person does not feel like they are facing an unmanageable task:

> "*you're doing your best to sort of overcome that and everyone's pulling their weight together and then you don't feel that, you don't feel that you're sort of facing to herculean a task" (John)*

Similarly, Sarah shared her experience of some people being reluctant to get involved until the risk has reached a certain level, which can leave certain professionals holding the risk more than others at various times throughout the pathway of the service:

> *"...like this guy was managed under GP, so psychiatry [were] reluctant to pick him up and sometimes the more services involved it actually can make it worse I think, but*

> *then the level of risk increased and it was like, no, no, we've got to now…so that's that's been helpful….now that we have a, it's like a bit of a relief that there are more, it's more of an MDT approach." (Beth)*

In the account below, John also highlights the limitations of working within a wider system. He highlights the idea that clinicians on their own may only be able to attend to a small part of a much broader and complex picture but that their role is necessary for the overall outcome. It emphasises the complex and interconnected nature of supporting individuals which becomes much more difficult if all parts are not working effectively together:

> *"So yeah, so I guess there's wider systemic issues also impact on the eventual sort of outcomes of people. And if you can, the difficulty you have is that you're part of, you're, you're sort of, one cog in a sort of complex wheel, and unless you get all those reins working together, sometimes it feels like it can be a sort of difficult process (John)*

Extending on some of the challenges, each of the 14 participants spoke about ongoing difficulties of working with external services when supporting individuals with mental health difficulties and suicide related risk. In particular, Sarah spoke about the difficulties that present when external services like social services are not in attendance, which can make professionals feel as though they are not involved:

> *"I do feel there's in this case unfortunately, the social care/NHS thing is tricky…..trying to bring us all together is often really difficult in these meetings, it's often social care that are absent, and I know for good reason they've got whatever else they need to be doing….but I don't think that helps in this case particularly, it's a bit like maybe they weren't involved…." (Sarah)*

Furthermore, the majority of participants also spoke about the lack of collaborative working between the LD service and the mental health services, which seemed to be a great source of frustration.

> *“there is kind of like a discussion amongst the team of whether the adult mental health team would be more appropriate because they're there to manage the mental health needs more than the physical health needs, I suppose, but then, understandably, the mental health team would sometimes say, well, actually we're not specialist in working with LD and, you know, maybe actually the LD Teams put a place for that. So there's sometimes a bit of a push and pull a bit of a go between, a bit of conversation across services.” (Kate)*

> *“Well we work with mental health as well, but the idea is that if someone's predominant need is their mental health, they would go to the mental health team, but as soon as they see learning disabilities, they bat them straight back to us….’no, they've got a learning disability’…..so it's it's an ongoing battle” (Lucy)*

> *“so sadly, with the mental health team, we just don't have any involvement. It's either it's either us or mental health team it seems and I really do think that it should be a when someone has a learning disability and mental health, I really do think that we should link in because, because you know, especially with our clients that have a very mild learning disability and it's always that argument, is it the mental health, is it a learning disability and quite often as soon as they've got a learning disability, it's it's on us and fair enough we do do, you know, we are also basically a mental health team, but they it I think it really would help to link in and be and work jointly, but we don't, we never do like there isn't there just isn't that it seems to be if they're under your team, they're not under us.” (Beth)*

> *"So they have got some understanding of LD, but it's not a specialist, and they are generic mental health.....so we've found that quite difficult, seeking appropriate support because they just they just for some reason don't want to or don't feel that they have the skills to work with adults with learning disability....but we need their expertise just like they need our expertise and it's it so frustrating that we can't work together". (Olivia)*

As mentioned above, a large proportion of participants spoke about their desire to have more joint working with MH services, where skills and knowledge could be shared across services. Participant spoke about organisational barriers and funding as issues that have further impacted the divide between services. Additionally, participants accounts also seemed to highlight a sense of services feeling ill-equipped and inexperienced to work with individuals with LD who are experiencing difficulties related to their mental health across both LD services and MH services:

> *"don't know whether it's a higher level commissioning thing. Because I know that sometimes that that's a huge barrier, the funding and the commissioning. But sort of a kind of. I just think it is that for some reason there's a stigma with working with adults with LD and autism. That, you know, they don't know how to adapt their communication. They don't know how to. You know, they don't know how to work with adults with quite complex intellectual needs and how to and how to adapt their approach. I think that's kind of not overtly been said, but you can kind of when we're speaking with the mental health teams, they don't feel like they have the specialist skills to to be able to adapt their treatment pathways to work with adults with such complexities. (Olivia)*

This ongoing debate highlights a potentially worrying perspective from external services that alludes to an all-encompassing understanding of LD, suggesting that individuals with LD do not have mental health needs separate from their LD needs and that the reason they are struggling is because they have an LD rather than an MH difficulty. Some participants they felt that 'political battle' could also infer a negative message to clients and further reinforce the idea that they do not 'belong':

> *....they're pushed away from mainstream health services, saying because you've got autism because you've got LD, we.... you're not part of what we can offer....you know, we don't....we can't help you.....we can't help you. And then they come to us.....and we say, well, really they should help you and we can try to help them help you.....but then they're they're caught in the middle of this constant political battle with our own services....and so the only message they get is that no one wants them" (Paul)*

For other individuals who have experienced working with the MH services spoke about needing to advocate and 'fight' for them to become involved in the care of some individuals, further emphasising the difficult relations between the services:

> *"....we fought to get her under mental health [services] for it because a lot of her problems were mental health related rather than the learning disability, and although obviously the learning disability did have an impact but she's now under mental health [services]. (Susan)*

Other participants, like Lucy, spoke about these relations having changed over time. She previously experienced working with MH services as being much more collaborative and cohesive in the past. She reflected on the wider political and systemic pressures that services are facing as a potential factor for the changes:

> *"well, I say that years ago, when I worked in a different office, we used to have really good relations [...] and would do some joint work, but now it's much more difficult….oh, and I don't know why that is…..I think… I know mental health services are really stretched as well." (Lucy)*

In addition to sharing of expertise as noted above by some participants, Lucy also noted that she felt that the divide between the services could be improved through a deeper understanding of each service, including what pressures they are under and helping the MH service developing insights into how mental health difficulties present for those with LD:

> *"I think it would be good for us to spend time in each other's teams to understand how they're working and what pressures they're under and for them to try to understand the people that we're working with and how their mental health can impact them when they've got a learning disability as well, I think that would be brilliant to do." (Lucy)*

Conclusion and Summary of Findings

The findings exploring professionals' experience of suicidality concluded that clinicians felt that although suicidality was not the most prevalent concern, expressions of suicide frequently prevailed for individuals with LD, with suicidality being viewed as one of the most complex issues to navigate in practice. Professionals reported that suicidality is more commonly observed in individuals with mild to moderate LD and often functions as a form of communication rather than a direct intent to die. Suicidal expressions were frequently linked to early life adversities, particularly trauma, exclusion and marginalisation, which often prompted loneliness, and persistent unmet relational needs. Many participants felt that suicidal ideation often reflected emotional distress, a desire for connection, or a learned relational strategy rather than a desire to end their life.

Assessing risk was understood as multifaceted, requiring a strong rapport to interpret the meaning behind potentially risky behaviour carefully. Challenges included determining individuals' understanding and intention behind behaviours, and clinicians noted some fears around directly asking about suicidality. Emotional and professional burdens were evident, with staff describing the weight of caring, concerns about responsibility, and the strain of working within system limitations. The importance of team-based approaches and sharing the 'load' was a dominant narrative that professionals valued for managing suicidality when it presents. Professionals consistently emphasised the value of peer support, supervision, and collaborative decision-making in reducing anxiety, increasing feeling of reassurance and navigating challenges associated with suicidality in practice.

Chapter Five: Discussion

Chapter Overview

This final chapter summarises the findings of the current study in relation to the research aims and existing literature. The strengths and limitations of the study will be discussed, along with clinical implications of the findings and any recommendations for services and policies regarding the management of presentations of suicidality within LD community services. The chapter will also include areas for future research and some personal reflections from the researcher.

Research aims

The current research aimed to explore professionals' experience and perspectives of suicidality as it presents for individuals with LD in a Community LD service. It also aimed to explore the process of accessing and managing this risk for professionals working in the LD service and consider the implications that clinicians' experience of managing suicidality has for clinical practice and service providers.

Overview of Findings: contextual and empirical interpretation

The study identified two overarching themes that capture professionals' experiences of suicidality in LD services. The first, *Understanding suicidality in the context of LD services*, highlights that while suicidality may not be the most common clinical concern, it is often viewed as one of the most complex. Professionals described the need to make sense of suicidal expressions through the lens of lifelong adversity and trauma, recognising that for many individuals with LD, suicidality can function as a form of communication, a means of expressing distress and seeking connection. The second overarching theme, *Working with suicidality in LD services*, explores the challenges of assessing and managing risk. This includes the difficulty of initiating conversations about suicidality, the emotional burden of care and professional responsibility, and the systemic constraints that impact practice. Emphasis was placed on the importance of collaboration and shared responsibility in managing risk, with professionals expressing a clear need not to work in isolation. The following section will expand upon each of the themes, providing contextual and empirical interpretations of the findings.

Understanding suicidality in the context of LD services

This overarching theme illustrates professionals' perceptions of suicidality and how it presents in clinical practice for individuals with LD. It emphasises how it is comprehended, the types of cases professionals consider it to be associated with, and the factors that contribute to it presenting within this population. Incorporating two themes, '*The nature and prevalence of suicidality in LD services'* and '*Making sense of suicidality for individuals with LD',* participants provide some clear insight into the nature of suicidality as it presents within LD services.

The data highlighted a wide range of suicidality-related experiences that professionals encounter while supporting individuals with LD, including self-harm, suicide ideation and suicide attempt, with some participants sharing their knowledge of suicide related deaths for individuals with LD. These findings heavily support the claim that individuals with LD can and do experience suicidal thoughts and behaviours, further discrediting the once claimed idea that individuals with LD were immune to such experiences (Dodd et al., 2016; Chan & Bhandarkar, 2024). However, the indication that suicidal experiences resulting in death were considered to be a much less common occurrence for the LD population, fits the existing thoughts that deaths by suicide are a lower reported cause of death for individuals in this population (Patja et al., 2001; LeDeR, 2022). Furthermore, the identification of suicidality as seemingly more prevalent in individuals with mild LD aligns with other research suggesting higher cognitive functioning is associated with increased experiences of suicidality (Walter et al., 2018; Dodd et al., 2016; Chan & Bhandarker, 2024). The theme spoke to the considerable differences noted regarding how suicidality is understood across the broad spectrum of LD. Participants reported that suicidality tended only to be experienced by individuals with a mild or borderline LD, which supports the claim that suicidal experiences are rarely, if ever, encountered with individuals with more severe LD (Harden & Sahl, 1999; Waters et al., 1995). These findings resurface the often-debated question of whether an LD diagnosis does indeed act as a 'buffer' against experiencing suicidality (Dodd et al., 2016). More explicitly, participants' narratives indicate that lower cognitive ability may protect against experiences of suicidality, but having a mild LD may only provide some protection from death by suicide, but not from the experiences. This was also emphasised in participants' reflections regarding feeling that individuals are not always able to engage in a plan that would result in death, indicating a potential barrier in the 'pathway to suicide' between the stages of 'pre-suicidal' and 'suicide act' for individuals in this population (Gibbons, 2024) as outlined by the psychodynamic theory of suicide.

Moreover, while it may be true that suicide deaths occur less frequently in individuals with LD, this could reflect challenges inherent in diagnosing this population. Mental health difficulties are often underreported due to diagnostic overshadowing or misattribution of symptoms (Mason & Scior, 2004; Patja et al., 2001; Dodd et al., 2016). Many participants acknowledged the difficulty in assessing suicidality in individuals with profound LD, particularly where cognitive impairments limit the ability to communicate distress. However, others appeared to overlook potentially suicidal behaviours in individuals with lower cognitive ability, attributing such behaviours to alternative causes, such as sensory processing, rather than considering suicidality. This pattern suggests that suicidality is perceived and understood differently across the LD spectrum. Given the heterogeneity in cognitive and communicative functioning, it is unsurprising that responses vary. However, the tendency to attribute similar behaviours (e.g., self-injury) to different causes depending on cognitive level reflects a significant issue in recognising suicidality among individuals with more severe impairments. This mirrors similar misattributions and differences seen in other diagnoses like personality disorder in LD populations (Deb et al., 2001; Alexander & Cooray, 2003; Gentile et al., 2022).

Ultimately, while self-injurious behaviours may indeed serve different functions across individuals, the consistent dismissal of suicidality in those with severe LD creates a risk of needs being addressed sufficiently. The prevailing assumption that this group does not experience suicidality reinforces a potential gap in both understanding and care. As such, suicidality in more profoundly impaired LD populations remains a significantly under-researched and poorly understood area, prompting the need for further research to be conducted on this topic.

The theme also noted that suicidality for individuals with LD, most frequently occur with individuals presenting with co-morbid conditions, namely personality disorders and neurodiversity in the form of autism, which aligns with the broader research around the higher rates of suicide and mental health difficulties found to be associated across these conditions both in LD and non-LD populations (McCllelland, et al., 2023; Brown et al., 2024; Chan & Bhandarkar, 2024; Dodd et al., 2016). Participants reflected their observations around suicidality within the LD population, tending to be more chronic, suggesting a long-term pattern, rather than acute episodes of suicidality, which has previously been noted as a feature related to personality disorders rather than acute disorders such as depression (Watt-McMahon et al., 2023). From the accounts of professionals in this study, this appears to fit for individuals with LD and may highlight that individuals with LD who meet the criteria for a co-morbid personality disorder present similarity to other populations with a personality disorder where suicidality is a feature. According to the diathesis-stress model of suicide

(Schotte & Clum, 1982), the presence of such diagnoses increases an individual's vulnerability towards experiences of suicide, which mirrors the perspectives of professionals shared across the interviews.

This second theme '*Making sense of suicidality for individuals with LD*' represents how suicidality is understood by professionals working in LD services, with the first sub-theme '*Vulnerabilities for potential suicidality: a lifetime of adversity and not fitting in*' illustrating the profound impact of early life traumas, including abuse, neglect, and abandonment, that individuals with LD are often exposed to. These findings echo broader literature on Adverse Childhood Experiences (ACEs), which have consistently been found to be strongly associated with later life suicidality and emotional dysregulation or distress (Thompson et al., 2019). The findings also reaffirm the strong link between social isolation and traumatic life events and suicidal behaviours for this population (Chan & Bhandarkar, 2024; Persechino et al., 2024), emphasising their likely role as risk factors for suicidality for this population.

Within this sub-theme, the chronic sense of social marginalisation, exclusion and isolation faced by individuals with LD was acknowledged. Suicidality was framed as an existential response to a general feeling that they do not 'fit in' or 'belong', rather than solely a symptom of a psychiatric disorder. In addition to having fewer social supports, individuals with LD frequently have fewer opportunities to integrate into society compared to the general population, including a lack of meaningful employment or vocation and limited activities to participate in, as highlighted throughout the interviews. These findings align with sociological and rights-based models of disability, emphasising the impact of structural and systemic disadvantage (Goodley, 2017). From a sociological perspective, experiences of suicidality for individuals with LD could be understood within the context of egoistic suicide as put forward within Durkheim's theory of suicide. Individuals experiencing a sense of detachment and exclusion from society, who are not integrated into society through employment, social involvement, or community, are more at risk of experiencing aspects of suicidality or attempting suicide (Gerardi, 2020; Bearman, 1991), which participants felt was highly relevant to individuals with LD experiencing suicidality.

The findings also support the concept of *thwarted belongingness* in relation to suicidality for individuals with LD as outlined within the interpersonal theory of suicide (Van Orden et al., 2010; Chu et al., 2018) presented in chapter one. Clinicians consistently felt that individuals with LD repeatedly felt that they did not belong, or that they not always feel like they fitted into society, with many individuals with LD experiencing ridicule, exclusion and lack of consideration within society. This was particularly prominent for individuals with borderline/mild LD, who often do not identify as having a LD but at the same time do not fit into mainstream services or the general population either, which was noted by professionals to potentially reinforce experiences of not belonging. The dimensions of thwarted belongingness include experiences of loneliness and the absence of reciprocal care or social inclusion (Van Orden et al., 2010), all of which are relevant for individuals with LD and may explain experiences of suicidality within this population. Nevertheless, the current study's support for the construct of *perceived burdensomeness* in relation to experiences of suicidality within LD populations was conflicting. While some participants highlighted that they were aware of individuals with LD experiencing suicidality who regularly felt like a burden, other participants argued that they did not feel that this applied to individuals with LD. Some participants felt that individuals with LD may not relate to experiencing it, due to the concept of burdensomeness being considered too complex to comprehend. Others felt strongly that experiences of suicidality were related to systemic issues of society not adequately providing for their needs, resulting in chronic exclusion and marginalisation, rather than it being associated with feelings of being a ‘burden’.

Furthermore, as mentioned in chapter one, the interpersonal theory of suicide acknowledges that suicidal behaviours are particularly challenging to act out under the premise that it defies our biological instinct towards survival. Subsequently, for an individual to attempt or complete suicide, they must develop the capability for this (Joiner, 2005). The theory assumes that this capability develops after repeated exposures to painful and difficult events, which reduce an individual's fear of death while simultaneously increasing their pain tolerance, making it more likely that they could attempt suicide. This aspect of the theory, as applied to individuals with LD, was heavily questioned within the current findings. Although many participants acknowledged that individuals with LD, particularly mild LD, generally understood the concept of death as related to suicide, the majority of clinicians reported that they did not always consider those individuals to have the cognitive capability to plan or engage with behaviours that were potentially 'risky' enough to result in death (e.g taking an overdose of three tablets instead of two). Although this could be argued as professionals' underestimation of potential risk, clinicians were aware that suicide can and does happen in this population, and therefore, this finding likely represents a potential disconnect between suicidal ideation and completing suicide for many across the LD population. From this perspective, it raises questions about the applicability of the interpersonal model, particularly in terms of capability, when understanding suicidality in LD populations. However, it may explain the low rate of suicide noted amongst individuals with LD, where a co-occurrence of the three concepts*, thwarted belongingness, perceived burdensome* and *capability for suicide,* does not tend to happen across this population, which the model assumes is necessary for an individual to attempt suicide. Nevertheless, it suggests the potential need for a new or adapted model that better aligns with the experiences of suicidality among individuals with LD, which further research should explore more in depth.

The second sub-theme *'suicidality as a form of communication; a source of seeking connection and containment'* continued with professionals understanding of the function of suicidality with many participants indicating that suicidality related presentations were often deemed to be a form of communication of distress, or a 'cry for help' rather than intent to die echoing perceptions of other professionals in the literature search in chapter two and explained in William and Pollock's (2001) "cry of pain model'. These understandings of suicidality for individuals with LD speak to the understanding that death is not often the intention behind it, but instead a method of expression.

Participants throughout the interviews also made multiple references linking experiences of abandonment and difficulties with early attachments and relationships. These findings mirror the idea that psychological difficulties in adulthood, including experiences of suicidality can often be linked to difficulties in attachment, with individuals with LD being understood to experience high rates of attachment difficulties (Hamadi & Fletcher, 2019), which were acknowledged throughout the interviews and considered to have a strong link to suicidality for the LD population. The interpersonal relationship between individuals with LD and the LD service was also referenced within this sub-theme, where suicidality was understood to be a learned style of relating to have their needs met or reestablish a connection. Suicidality-related difficulties were predominantly considered to be a function of re-establishing connection and containment, particularly from professionals, which could be understood through an attachment theory lens, where suicidality acts as a way to gain closer proximity to those who provide care and support. As highlighted in other papers looking at attachment in LD populations, individuals with LD may have limited skills in theory of mind, which is necessary for the development of a secure internal working model of attachments (Fletcher & Gallichan, 2016; Hamadi & Fletcher, 2019). Consequently, if individuals with LD have not developed this, they may continue to require close physical proximity to feel safe and secure (Fletcher & Gallichan, 2016) which may result in increased expressions of suicidal ideation to fulfil this need. This is likely further exacerbated by an individual's minimal or limited circle of support and thereby having less of a pool of people to establish a secure base with, other than those that support them from the LD service. Holding this relational element of suicidality in mind, these finding highlight the need for further inclusion of attachment theory in clinical practice when working with LD populations, particularly for understanding and addressing suicidality, which supports the recommendation made by those looking at attachment in LD populations (Hamadi & Fletcher, 2019).

Working with suicidality in LD services

This overarching theme presented the experiences and perceptions of staff regarding working with it as it presents in clinical practice. More explicitly, through the three themes *Determining the risk and having the difficult conversations; Navigating capacity, understanding and communication, the weight of working with suicidality* and *the importance of working together, sharing the load and not working alone with risk* a comprehensive picture is presented providing great insight into how suicidality is experienced by professionals working in the service.

The theme *determining the risk and having the difficult conversations: Navigating capacity, understanding and communication,* highlighted the relational and dynamic nature of risk and the centrality of the relationships when comprehending risk. Participants emphasised the importance of developing trust and rapport to facilitate safety for individuals to disclose suicidality-related concerns, which has previously been identified as a crucial element when conducting mental health assessments in vulnerable populations where communication may be atypical (Hemmings et al., 2013). According to participants, developing a strong rapport fosters openness and more accurate disclosures of risk, including aiding professionals to more easily determine the meaning behind some expressions that could be associated with suicidality, which would not be possible without prior knowledge and understanding of the individual. These findings support those presented in the literature search in chapter two, where professionals placed great value on ‘knowing the individual and their history well when determining the level of risk and ascertaining the meaning of presentations and behaviours (Reid et al., 2024; Bajaj et al., 2008).

Within this theme, participants also reflected on the challenges they encountered when determining the intention behind suicidal expressions for individuals with LD. In terms of understanding the concept of suicide and death, a few participants expressed that they felt some individuals, mainly those with borderline or mild LD, had a basic understanding of suicide. However, many clinicians questioned whether many individuals were able to grasp the concept and queried whether they fully comprehended the finality of death and the potential consequences of their behaviours. This query reflects the long-standing debate that exists in the literature around whether individuals with LD can understand complex phenomena such as death (McEvoy et al., 2012). Although it has been widely acknowledged that many individuals can comprehend the concept of death, these findings suggest that many clinicians continue to hold much uncertainty about this or at least question the depth of comprehension. Professionals perceiving individuals as incapable of fully understanding death and suicide, due to cognitive limitations, may inadvertently minimise risk or delay appropriate support. While some participants acknowledged these biases, many still expressed uncertainty about how to disentangle intent, understanding and function of suicidal presentations, highlighting a critical gap in support and awareness. The varying degrees to which participants felt individuals with LD understand suicide and death indicate that this is not binary (knowing or not knowing) but rather exists on a continuum that varies from person to person and requires careful consideration when conducting a risk assessment. While determining understanding surrounding death in this population may be difference, it is also worth noting that other professionals in the literature search also spoke about the challenges of determining intent, indicating a more universal experience of professionals working with suicidality.

Furthermore, research by Werth et al. (2002) and Wagemaker et al. (2020) suggests that emotional suffering, a wish to escape pain and influence from peers significantly impact an individual's desire to die or engage with risk behaviours. This suggests that a full cognitive grasp of the finality of death is not a critical indicator of risk, emphasising the importance of taking all expressions seriously. Throughout the interviews participants pointed out that the distress remains the same regardless of their level of comprehension and perceived capability, acknowledging the importance of displacing the focus of understanding the concept of death towards a better understanding of whether they are suffering in a way that they might take action to escape unbearable pain and addressing the factors that are contributing to them experiencing suicidality in a person-centred way. In addition, as pointed out in the psychoanalytic pathway to suicide frame in chapter one, the double bind of wanting to end the pain but also wanting to live is a common experience of a 'pre suicidal' state (Gibbons, 2014), which appears to fit for the presentations of suicidality for individuals with LD as described by professionals, which can generate feelings of ambivalence and confusion. According to the model, the key to determining the level of inherent risk lies in identifying which side of the double bind 'pre suicidal' state the individual is presenting in at the time of the assessment, which might support professionals to determine risk more effectively in this population.

The findings presented in this theme also highlight a potential inconsistency across the service regarding the assessment of suicidality, with many clinicians stating that they do not tend to ask unless it is warranted. Several participants reflected on some implicit or unconscious bias they held regarding individuals with LD, which appeared to present as a barrier to exploring suicidality in this population. Alongside thoughts of individuals with LD not having the capability for suicide, some clinicians acknowledged that they found it hard to explore suicidality with individuals who presented as "childlike". This perception, often referred to as the **"**eternal child**"** stereotype, is grounded in care and protection (Michals & McTieran, 2018), but appeared to influence how professionals approached risk assessment and whether they believed their clients were capable of suicidal intent. These accounts reveal how the infantilisation of adults with LD continues to exist for some professionals, which may compromise clinical vigilance, shape risk formulations, and reinforce a barrier to comprehensive explorations of suicidality in practice.

Furthermore, this theme also alludes to the existence of further hesitation from some clinicians regarding perceptions and fears surrounding the potential iatrogenic harm, which was also noted by other clinicians in the literature search (e.g Bajaj et al., 2008). Despite research supporting screening for suicidality (DeCou & Schumann, 2019; Dazzi et al., 2014) and suicide prevention strategies and policies advocating for the process of screening for suicidality outweighing any harm, there appears to be some ambivalence about raising the topic of suicide with individuals with LD. Participants acknowledged their fears about questioning, consisted of fears around making things worse or 'planting a seed' triggering further risk, which may be particularly present for clinicians lacking experience of addressing Nevertheless, other participants spoke about feeling confident about talking about risk, which they attributed to previous encounters of managing risk, highlighting the value of experience, echoing the thoughts of other clinicians working with suicidality in other populations highlighted in the literature review in chapter two (Leddie et al., 2021; Chandler et al., 2015).

The theme, *the weight of working with suicidality*, provided deep insights into the impact of working with this type of risk in clinical practice. Incorporating two subthemes, *The Weight of Caring* and *The Weight of Professional Responsibility and the Limitations of the System*, outline the emotional heaviness and sense of responsibility that clinicians reported to be associated with handling risk cases. Professionals frequently described the emotional impact of working with suicidality, with participants describing it as emotionally challenging. The emotional impact of working with risk on clinicians has been consistently reported in the literature. Findings of the current study reflect that stress and burnout are clear features of caring professions and commonly reported experiences amongst NHS staff (Johnson et al., 2018; Wilkinson, 2015; Iacobucci, 2021) and working with suicidality as noted in the literature search (Chandler et al., 2015; Briggs et al., 2017).

Participants also acknowledged the pressure of their professional responsibilities and the weight of navigating suicidality concerning their duty of care as a clinician, particularly when they are the sole professional involved in the care of an individual. These experiences mirror the findings presented in the literature search, with professionals experiencing a similar sense of pressure and responsibility for an individual's wellbeing and recovery (Leddie et al., 2021). Furthermore, participants spoke to the underlying existence of a 'blame culture' that potentially exists in the service, which Khatri and colleagues (2009) report may stem from a bureaucratic 'rule and compliance' style of managing services, which can limit growth and learning. It could be helpful for services to consider this when considering how best to support staff wellbeing in an attempt to lessen the pressure felt by professionals, which appeared to be linked to the weight they feel when navigating suicidality.

The theme, *the importance of working together: sharing the load and not working alone with risk* emphasised the importance of working collaboratively when supporting clients with suicidality, which participants felt the LD team were particularly good at. Multidisciplinary teamwork and regular team meetings appeared to provide clinicians with emotional containment and reassurance when faced with managing risk. Furthermore, when risk was shared, clinicians felt safer, more supported, and less isolated in their decision-making. Clinicians reflected on the importance of supervision and more informal peer support when dealing with challenging cases, as they felt the more formal supervision in the form of a debrief was established practice following a serious incident, but 'everyday' peer supervision was less embedded within the team.

In addition, participants frequently referenced the broader political and structural debate that exists about who should be providing the care and support of mental health difficulties, for individuals with LD (Hemmings, Bouras & Craig, 2014). Despite guidelines advocating for individuals with LD to be able to access mainstream healthcare services where possible (Hemmings et al., 2014), participants illustrated the difficulties they have with secondary care mental health services accepting referrals they send for individuals with LD. Some participants highlighted that the non-acceptance of referrals may reinforce an already existing negative narrative and message of further exclusion and not fitting in for the LD population, further marginalising them as individuals. Professionals' frustrations towards the low rate of acceptance of referrals mirrors the experiences of other professionals working with suicidality in non-LD services as outlined in the literature search (e.g Saini et al., 2016; Bajaj et al., 2008), indicating that this is not a unique experience in LD services. However, it shines a light on a broader issue that exists regarding the care and support of the mental health needs of individuals with LD. As noted by Hemmings et al (2014), the policy encouraging the use of mainstream services for this population regarding their mental health difficulties, where possible, is not evidence-based and calls for further research into the effectiveness of interventions for managing suicidality in clinical practice (Foundation for

People with Learning Disabilities, 2004). They also advocated for the development of ‘new ways of co-working with staff in ‘mainstream’ mental health services’ as the way forward, which echoes the aspirations of clinicians working in LD services towards a more collaborative way of working with external services.

Clinical Implications:

The heavily indicated link between suicidality and previous trauma and adversities speaks to staff-wide knowledge and awareness of trauma-informed presentations and behaviours across the various disciplines within LD services. Interventions to reduce suicidal ideation among individuals with LD who are survivors of childhood trauma should focus on support for such individuals alongside attempts to increase their social support and social integration. These findings align with and support the continued integration of trauma-informed care models within LD services and supports. They emphasise the need to understand behaviours, including suicidality, not as “challenging” but as adaptations to traumatic experiences and adverse life experiences, which individuals with LD are regularly exposed to. In terms of suicide prevention policies (Staying safe from suicide; NHS, 2025), the findings suggests that LD services would value from further embedment and implementation of the recent guidelines around suicide prevention which aims to go beyond risk management to engage in trauma formulation of presentations, validating distress, and fostering of psychological safety in targeting and working with suicidality in clinical practice. Additionally, the findings emphasise the ongoing systemic failings towards providing more inclusive opportunities for individuals with LD, particularly around employment opportunities and meaningful activities, where a lack of provisions in these areas is considered to be contributing to chronic exclusion and loneliness, which likely contribute to experiencing suicidality and distress. The findings highlight the urgent need to address these issues to improve the psychological wellbeing of individuals with LD, in line with the policies and guidelines for the care and support of individuals with LD (NHS, 2015).

Clinically, based on the findings of the current study, it would also be beneficial to increase the availability and accessibility of attachment-based interventions for individuals experiencing suicidality and consider ways to increase attachment security, which may minimise distress and suicidality for individuals with LD. This mirrors broader indications that attachment work can be a crucial element in working with individuals with LD who experience mental health concerns (Mikulincer & Shaver, 2012). The findings advocate for the increased implementation of attachment theory across LD services to understand and manage suicidality in clinical practice, in line with the British Psychological Society and Royal College of Psychiatrists' guide, '*Incorporating attachment theory into practice: Clinical practice guideline for people with intellectual disabilities'* (BPS & RCP, 2015), Increasing awareness of attachment difficulties and how they present in individuals with LD may support professionals when formulating and understanding suicidality and risk. Given the finding that suicidality can be considered a relational style, it may also be helpful for professionals to gain a better understanding of their own attachment style and approach to relating, considering how it may influence the individual's relationship with the service and the presentation of suicidality. Furthermore, as noted by Hamadi and Fletcher (2019), little focus has been placed on the relationship between professionals and those they are caring for, where increased understanding of attachment difficulties in this population could support professionals to help individuals with LD to develop and maintain better quality relationships as outlined in the white paper Valuing People Now (Department of Health, 2009), which may also reduce suicidality presentations. Nevertheless, further research is required to understand the link between attachment difficulties and suicidality in this population and how attachment-based interventions may be effective in reducing the prevalence of suicidality for the LD population. Nevertheless, it seems that there may be value in considering strategies for expanding the social supports for individuals with LD and develop ways for those within the social supports (e.g carers) to be the ‘secure base’ from which individuals with LD achieve better wellbeing (Skelly, 2016 as cited in Hamadi & Fletcher, 2019).

Strengths and Limitations of the current study

To the best of the researcher’s knowledge, this is the first study to explore suicidality in the LD population from the perspectives of professionals working in Community LD services in the UK. Much of what was previously known and understood about suicidality in the LD population was based on retrospective data, predominantly from case studies, which can be subject to bias and a lack of generalisability (Chan & Bhandarkar, 2025). The current study offers nuanced and significant insights into how suicidality presents in individuals with LD. It also provides deeper insights into some of the risk factors and experiences of managing it in clinical practice, all of which contribute to current empirical knowledge regarding suicidality in LD populations.

The sample used in the current study is both a strength and a limitation. The sample included participants from various professional backgrounds, which provided broader insights and perspectives than would have been achieved if the sample had focused on one profession (e.g., nurses). This enabled interprofessional dynamics and perspectives to naturally emerge from the data providing a deeper and nuanced ability to address the research aims. Subsequently, the findings presented are likely to be more applicable to a variety of settings, making the results increasingly more relevant for implementation in clinical practice and policy relating to LD services. Nevertheless, it resulted in potentially less unified experiences being uncovered, as the background and training experiences of the various professions, such as a nurse compared to a psychologist, are vastly different and may have influenced the findings. The results were reflective of various clinicians' positionalities within the service, alongside their respective professional governing bodies and training backgrounds. Additionally, the study was conducted within one central NHS LD service, and although this covers a wide geographical area that once comprised of two distinct NHS trusts, the study recruited participants from a now unified service. The findings may not accurately represent the experiences of clinicians in other NHS trusts across the UK and may be limited in terms of their generalisability. Nevertheless, the strength of including a variety of professionals' perspectives in providing an in-depth exploration of suicidality should not be dismissed. However, future research should expand on the current findings.

Furthermore, the use of purposive sampling, which focused on individuals who have encountered suicidality in their clinical practice, enabled the study to provide a deeper exploration of the concept of suicidality. However, the findings presented in this study may be subject to bias, as all participants had some degree of experience working with suicidality as per the inclusion criteria and therefore may not represent the general experiences of other clinicians in the LD service. It could be helpful to consider broader understandings and perspectives of suicidality in the LD population from a wider range of clinicians, including those who may not have been eligible for this current study, in future research studies. Incorporating clinicians' views on suicidality in this population, regardless of experience, may provide further insight into the culture and attitudes towards suicidality more generally in LD services. This may generate a more comprehensive picture of understandings and perspectives of suicidality in this population.

Additionally, although the study adhered to the recommended guidelines for a professional doctorate research project implementing reflexive thematic analysis (Clarke & Braun, 2013), it is unclear why only 14 clinicians participated in the study. Several participants mentioned that they were aware of colleagues who met the study's criteria, with some stating that their colleagues had expressed interest in participating. However, they did not respond to the invitation, which suggests that there may have been potential barriers to their participation. While it could be assumed that this was due to time constraints that clinicians in the NHS are privy to, it may highlight a wider cultural reluctance towards discussing suicidality in LD populations. It may also be reflective of the limited space for reflective thinking available to LD clinicians outside their required professional duties, as indicated in participants' accounts, highlighting a desire for more informal reflective spaces. Several participants spoke about not having ‘much’ experience of suicidality in this population and although it was mentioned on the advertisement for the project that it included the broad range of suicidality it could be assumed that there were many other participants who may have been eligible to participant but may have felt like they were required to have experienced a client, or multiple clients, attempt suicide or died by suicide to take part.

Furthermore, despite addressing the research aims, it is essential to acknowledge that the current study does not include the voices of individuals with LD regarding their experiences of suicidality. It is widely known that individuals with LD are underrepresented across all research, often due to issues with recruitment methods and/or consent issues (Mencap, 2016). Nevertheless, to get the most out of findings of research, individuals with LD need to be represented in research and with minimal research having been conducted exploring suicidality in LD that includes the voice of individuals with LD (Mencap, 2013). There is a call for more research in this area, including individuals with LD, to provide further understanding of the experiences of suicidality for this population.

Reflections

Conducting this research has been both academically and emotionally demanding. Engaging with the literature on suicidality significantly deepened my understanding of the concept, both in general and specifically concerning individuals with LD. At the outset, I found the breadth of existing literature overwhelming; however, narrowing the focus to the LD population provided a manageable framework and a more purposeful direction for the research.

The process of thematic analysis was unfamiliar to me prior to this project and offered a meaningful opportunity to engage with participants' narratives, expertise, and experiences. I was particularly struck by the emotional burden described by participants, a burden shaped by a profound sense of responsibility and duty that existed in parallel to a deep commitment towards improving the lives of individuals with LD. I was drawn to this emotional 'weight' that consistently came up, which is often taken for granted as simply 'part of the job' and, therefore, rarely acknowledged. As I near the end of my clinical psychology training, I am increasingly mindful of the importance of creating safe spaces and opportunities where clinicians can reflect on risk and the emotional impact of their work; something that participants consistently identified as valuable.

One of the most significant insights to emerge from this research was the potential link between suicidality and attachment difficulties, which I hadn't previously considered in my risk assessments. This prompted a shift in my thinking and approach to suicidality, and I now intend to reflect on this and the impact it may be having when engaging with formulations around risk.

The reflexive aspect of this research proved essential in enabling me to identify and bracket my assumptions, process emotional reactions, and critically examine how my positionality may have influenced the interpretation of data. It also helped me remain grounded in the rationale for the numerous analytical decisions required throughout the research process. This has strengthened my confidence in articulating and justifying the choices I have made and discussing my research with clarity and critical awareness.

Furthermore, through this reflective process, I also became aware of moments where it was challenging to maintain a neutral stance during interviews, for example, when participants spoke of sadness, anger, and helplessness in the face of systemic barriers. As a clinician, also working in the NHS system, I found myself mirroring some participants' emotional responses. At times, I struggled to imagine realistic improvements within what felt like an inflexible and hopeless system, which at times felt overwhelming. Keeping a reflexive journal helped me to identify and process these emotions without allowing them to overly influence the research.

Participants' reflections on perceived blame cultures and anxieties surrounding professional accountability led me to consider the broader systemic structures within which risk is managed. These insights encouraged me to think critically about my role as a clinician, not only in supporting individuals, but also in challenging systemic norms or cultures that may perpetuate blame and fear, thereby preventing learning. I am increasingly committed to promoting work environments that focus on learning and reflection over blame.

Nevertheless, despite these challenges, I was deeply humbled by the compassion and care participants demonstrated toward their work. I was particularly struck by the high regard in which participants held their colleagues and team. Contrary to my expectations, there was minimal reference to internal challenges such as staffing issues. Instead, the ethos of the team was described in a predominantly positive light, which felt somewhat unique to professionals working in LD services.

As I conclude this research, I do so with a deepened curiosity and a renewed commitment to continue learning, both about suicidality and the wider systemic and relational patterns that shape clinical practice. This project has been pivotal, not only in expanding my academic and clinical knowledge but also in shaping the kind of clinician I aspire to become.

Conclusion:

In conclusion, this study is the first study in the UK to explore how professionals working with individuals with LD experience and perceive suicidality in LD populations. The findings also reflect its perceived function, alongside some of the risk factors and the emotional weight of working with suicidality on a personal and professional level. Furthermore, it highlights various implications and recommendations for services working with suicidality, including the need to extend trauma-informed care and attachment theory to individuals with LD experiencing suicidality. Moreover, finally, though this research has also identified multiple areas for future research, indicating that much more is still to be known and clarified, the findings have provided nuanced insights into a complex and important area that is crucial to consider when working with individuals in the LD population.

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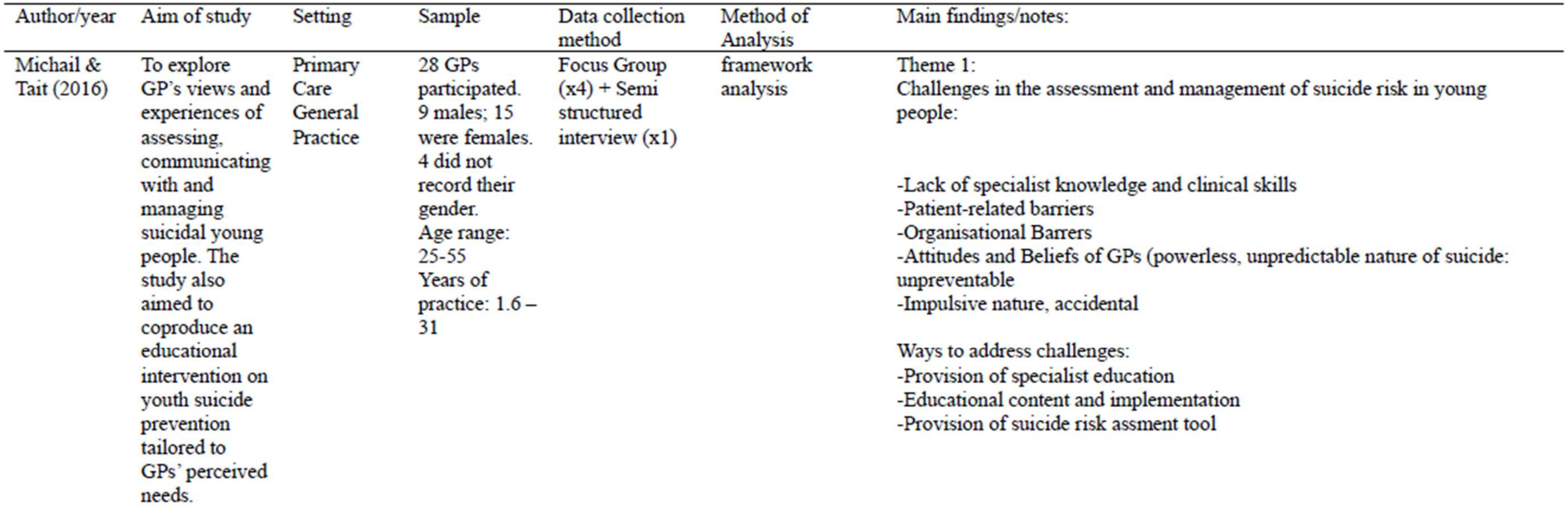
Appendices

Appendix A – Summary of papers for literature review



Author/year	Aim of study	Setting	Sample	Data collection method	Method of Analysis	Main findings/notes:
Michail & Tait (2016)	To explore GP's views and experiences of assessing, communicating with and managing suicidal young people. The study also aimed to coproduce an educational intervention on youth suicide prevention tailored to GPs' perceived needs.	Primary Care General Practice	28 GPs participated. 9 males; 15 were females. 4 did not record their gender. Age range: 25-55 Years of practice: 1.6 – 31	Focus Group (x4) + Semi structured interview (x1)	framework analysis	Theme 1: Challenges in the assessment and management of suicide risk in young people: -Lack of specialist knowledge and clinical skills -Patient-related barriers -Organisational Barrers -Attitudes and Beliefs of GPs (powerless, unpredictable nature of suicide: unpreventable -Impulsive nature, accidental Ways to address challenges: -Provision of specialist education -Educational content and implementation -Provision of suicide risk assment tool

Saini, P., Chantler, K., & Kapur, N. (2016)	to explore GPs' interpretations of patient communication and treatment in primary care leading up to suicide and to investigate the relationship between GPs and mental health services prior to a patient's suicide	General Practice	GPs (N=39) Eleven of the GPs were female, 28 were male and the length of time since qualifying ranged from 8 to 37 years, with an average of 19 years	Semi-structured intervs	Thematic Analysis	1. GP interpretations of suicide/self-harm: Variation in recognising seriousness; some saw it as attention-seeking. 2. Professional isolation: Barriers in access to secondary care, lack of support, and frustration with services. 3. GP responsibilities vs. patient autonomy: Tension between respecting patients' choices and fulfilling duty of care, especially where patients declined treatment or missed appointments.

Reid, Edge, Pratt & Wittkowski (2024)	To explore the experiences and perceptions of mental health professionals working in perinatal services who have worked with suicidal mothers during the perinatal period.	NHS specialist perinatal mental health services	15 perinatal mental health professionals: consultant psychiatrists (4), trainee psychiatrist (1), clinical psychologists (3), community operational services manager (1), ward manager (1), two staff nurses, nursery nurse (1) and OT (2): White British (12), mixed White and Black Caribbean (2), British Indian (1), female (11), male (4).	Semi-structure interviews	Reflective Thematic Analysis	**1 Factors Linked to Suicidal Ideation and Behaviour** **A. The Mother's Context: Lack of or strained social support (e.g. relationship breakdowns), Overbearing but well-meaning support networks, Support was not always protective if the mother's internal struggles remained unaddressed.** Early life experiences and whether the pregnancy was wanted influenced risk levels. **B What the Baby Represents:** Mother's perception of the baby: breastfeeding and caregiving shaped attachment and self-worth Breastfeeding success = adequacy and protection; difficulties = feelings of failure. Baby could represent failure or inadequacy, worsening suicidal thoughts. Mother's interpretation of baby's interactions influenced self-perception/feelings of being unlovable or not good enough. **2 Communicating About and Identifying Suicidal Ideation and Behaviour** **A Talking About Suicide:** Professionals needed to create safe, non-judgmental spaces: **Understanding context:** including fear of child protection services. **Building trust:** essential for disclosure and open communication. **Noticing non-verbal cues:** as many mothers may not verbally express suicidal ideation. **B Types of Suicidal Ideation and Attempts:** All S ideation to be taken seriously: fleeting, passive, and active thoughts. Suicidal actions may result from sudden despair, overriding protective factors. Suicide attempts varied: Some as communication; others reflected clear intent. **3: Reducing Suicidal Ideation:** reshaping the mother's self-perception and view of her baby. Highlight the mother's unique value and irreplaceability; Emphasising the mother–baby bond and her importance to the child; Encouraging hope that attachment and confidence can grow even if initially weak.

Briggs, Slater, & Bowley., 2017	To explore MH practitioners experience working with YP who engage in suicidal behaviour amongst peers	Child and Adolescent Mental Health Service (CAMHS)	four nurses, two psychiatrists, two psychologists, one social worker and one family therapist.	Semi-structure interviews	Thematic Analysis	1 Risky and protective connections: Influence from peers, S generated through connections 'Trellis' 'crystallize and grow' Mutal influence: the double edge Balancing the need for groups/friendships Vs managing the risk: The do 2 Managing risks, dilemmas and challenges: Difficulties understanding the meaning and risk-how near to dying they were, Bonding in the group could be experienced as exciting and increase risk (getting high and taking things too far -Risk viewed as being lower by those remaining in contact with the service: higher risk by those who are isolated/not in contact: 'They won't advertise it' -Challenge of online; and managing risk Confidence comes with experience -Need for training of online risks -Taking account of the emotional impact is important: Anxiety Vs over reacting -Holding boundaries

Bajaj, Borreoni & Ghosh et al., 2008	To examine attitudes of both general practitioners (GPs) and patients toward screening for suicidal ideation in primary care, including reactions to being asked such questions and perceived potential harms.	Primary Care Practices	103 GPs	Mixed methods: Survey GPs and interviews of patients *Only survey responses were included in the study	Thematic framework:	The majority of GPs supported the screened patients with: -Easier to ask when an individual has a disorder already. Main reason for screening: -To assess and manage risk -Don’t always ask if SH Helped open up dialogue on sensitive issues Made patients feel comfortable discussing suicidal thoughts A need for: Further training and education on suicide assessment and screening Key barriers to screening included: Time constraints Cultural and language challenges with ethnic minority patients (e.g., interpreters, differing views on suicide) Personal fear or embarrassment about asking Concerns about making things worse or "opening a can of worms”

Leddie, Fox & Simmonds, 2021	To explore the experiences of community psychiatric nurses (CPNs) working with adolescents who self-harm in community settings.	Community Child and Adolescent Mental Health Services (CAMHS)	10 CPN 8 female 2 male	Semi-structured interviews	Interpretative phenomenological analysis	: Personal and professional conflicts 1a: “keeping everyone happy: Balancing the needs of everyone, Conflict and challenges while maintaining positive rapport, holding the families wishes in mind too 1b “double-edged sword” Managing conflicts with internalised responsibility and competing demands, personal responsibility, feeling proud when progressing but a failure when not 2: Personal and professional development The ways learnt to manage the conflicts and difficult emotions they experience, 2a: “I can switch off … from being a professional, and be a person” -tolerate uncertainty, manage emotions -Findings way to switch off -Seeking reassurance from colleagues, sharing the responsibility, formal and informal discussions. Challenging self-doubtvalidate the emotional response and normalise self-doubt, remind themselves of the positive rewarding part of the job 2b: “it has got easier, just with experience Overwhelm and anxiety get better with experience; learning on the job, learning from clients and colleagues, training, but potential for emotional desensitisation.

Chandler et al., 2015	To explore How GPs respond to patients who have self-harmed: considering the link between SH and suicide, and approaches to carrying out suicide risk	Primary Care	30 GPs 16 male 14 female	Semi-structured interviews	TA with a narrative approach	Complex relationship between SH and suicide: may indicate low risk (SH as a protective factor), but could indicate high risk, difficult to disentangle. -SH used to release emotions, communicate distress, and be seen as a way to seek help, not really wanting to kill themselves; those who do would not say. -A 'Cry for help' was noted for SH, but also for a suicide attempt -Unable to be sure; fear going on in the background; degrees of suicidality, and this is different for everyone -Understood as a response to difficult situations in an individual's life Challenges: Time constraints, assessing intent, Needing to know the individual's circumstances Variations in levels of confidence: desire for a specialist input

Fox et al., 2015	To explore GP's capabilities, motivations and opportunities for discussing self-harm and to identify barriers to and enablers for proactively discussing self-harm with young people.	GP	Of the 28 GPs who completed the online survey 7 were male and 21 were female, with an age range of 20–60 years. Ten GPs participated in telephone interviews with the qualitative research assistant (GC), of whom nine were female and one was male.	Survey and semi-structured interviewd	Inductive Thematic Analysis + Descriptive Statistical	Theme 1: GPs' skills, knowledge and perceptions about young people and self-harm **Knowledge:** Variations on the frequency of how often they asked about SH: not seeing it but could be due to not discussing it **Perceptions:** -Linked to other social and emotional problems, poor MH -Acute episode -A coping strategy **Skills** -Lack confidence, anxious about the potential risk of suicide, this is dependent on experience -Training and education would be helpful Theme 2: Identifying, talking to and supporting young people who self-harm **Identifying** -Parents as enablers and a barrier to asking about risk; try to talk to YP alone and navigate confidentiality and share risk with parents, age-dependent. **Talking** Usually asked as routine practice, but might not ask in first appointment to prioritise building rapport unless their were major concerns -asked carefully and sensitively -Screening tool would be helpful, but hard to do in the 10 minute slot and ensure they feel listened -Concern asking may have negative consequences but thought that it should never be ignored -Using the language the YP does, building trust **Supporting** -'part of the service' -Providing 'stop gap' waiting for referrals Challenges: when SH is not deemed severe enough for referral to be accepted and there are no alternatives -Sign posting but aware that YP may not be confidence enough to access -Follow up with person -Ongoing training education and practical information

Saini et al., 2010	The aims of the current study were to describe services available in general practices for the management of suicidal patients and to examine GPs views on these services.	GP	159 GPs	Semi-structures interviews + Survy	Framework analysis: TA	Barriers to working with MH services: -Hard to access, referred back, Long wait lists, rigid criteria, under resourced, -GPS feel unsupported in the decision-making -Managing changes in MH provisions

Appendix B – CASP Quality Appraisal

CASP Quality Appraisal of papers selected for literature search

CASP Criteria Key as outlined by Long et al., (2020) 1= Yes 2=No 3=Somewhat 4=Unclear/Can't tell	*Reid et al., 2024*	*Bajaj et al 2008*	*Briggs et al, 2017*	*Saini et al., 2016*	*Leddie, Fox & Simmonds, 2021*	*Chandler et el., 2015*	*Michail & Tait, 2016*	*Fox et al. 2015*	*Saini et al. 2010*
Was there a clear statement of the aim of the research? (Y/N)	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	Y	y
Is qualitative methodology appropriate? (Y/N)	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*y*
Was the research design appropriate to address the aims of the research?	*1*	*3*	*1*	*1*	*1*	*1*	*1*	*1*	*1*
Was the recruitment strategy appropriate to the aims of the research?	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*
Was the data collected in a way that addressed the research issue?	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*
Has the relationship between the researcher and participants been adequately considered?	*3*	*4*	*1*	*3*	*1*	*4*	*1*	*4*	*4*
Have ethical issues been taken into consideration?	*1*	*3*	*1*	*1*	*1*	*3*	*1*	*4*	*4*
Was the data analysis sufficiently rigorous?	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*3*
Is there a clear statement of findings?	*1*	*2*	*2*	*1*	*1*	*2*	*2*	*2*	*2*
How valuable is the research?	*1*	*3*	*1*	*1*	*1*	*1*	*1*	*1*	*1*

Appendix C - Extracts from the researcher's reflective journal

Field notes following first interview: 'The novice researcher'

I noticed I was particularly nervous prior to commencing this interview as it was my first one. In particular, I wondered what the participant expected from me and had thoughts around whether I would be a 'good enough' researcher. I also wondered if she expected me to be an 'expert' in suicidality in LD which made me nervous, as I worried about her asking me questions that I could not answer, as I very much felt like a novice.

Throughout the interview, I found myself worrying about not leading the direction of the conversation and questioned whether it was ok to ask questions that were not directly on my topic guide but still related to the general topic. I feel like this blocked my curiosity, which may have resulted in the interview being slightly shorter than anticipated at 43 minutes-next time I will try follow my curiosities and clarify further points made by the participant.

I felt a strong sense of frustration from the participant, particularly with the relationship between MH services and the LD team-the fight between MH vs LD-Could this be a factor for the services as a whole? As well as belonginess/Loneliness: I wish I has asked more follow up questions about this.

I also notice the use of the term 'attention seeking'-although they corrected this to gaining support-I wonder if this reflects a potentially negative view of the types of cases that are associated with suicidality in this service-the word complex was also used. I will continue to monitor this across the next few interviews and see what emerges.

I was struck by the length of time this participant has worked in LD services and was in awe at the breath of her knowledge and experience in LD. This excited me with regards the value of this, particularly as she noticed a changing increasing trend in suicidality in LD services-I wonder if others might say similar.

Field note following interview number 4: 'the heaviness'

Wow, what a deep conversation!!!

I am definitely feeling more confident now with regards conducting interviews and notice that they feel more dynamic and conversational rather than 'interview'. My clinical skills seem very relevant for this type of research. I also feel more adept with my use of the topic guide in the way it was intended to be implemented (using it flexibility, keeping the conversation on track but also allowing for the individual to share unique perspectives). It also felt more natural to navigate the topics in a more unstructured way, where I felt more able to track that the topics had been covered without the need to stick rigorously to the guide-I think this helps make it feel more like a conversation.

I noticed a particular 'heaviness' associated with todays interview., an almost existential type of interview. The participant spoke the impact of 'care' and the double edge of being in a caring profession where looking after others often gets prioritised, 'the double edge of care'.

This interview brought up various responsibilities, including clients and staff, and feeling like it is your responsibility to improve things. I too found myself feeling the 'weight' associated with feeling responsible for the wellbeing of others-a gentle reminder to myself to speak about this in supervision and acknowledge that 'everyday work' can be challenging and emotionally demanding, even if it is 'part of the role'.

The participant had a clear sense the commitment towards improving services for individuals with LD, which I admired. He also noted a clear desire for a better system where individuals feel like they 'belong'. – This belongingness theme has presented again- the sense that individuals with LD don't feel like they belong, resulting in loneliness seems to be a factor that has been consistently mentioned in relation to suicidality with each participant so far. Frustrations with system structures and limitations propelled a sense of hopelessness and tiredness towards 'fighting' for improved services for LD.

Example of researcher reflections outlining some decisions made throughout the research:

'intellectual disability' Vs 'learning disability'

I commenced this study using the term intellectual disability, as this is what is used in academia, and I completed my ethics application and thesis proposal using this term. However, through my engagement with the socio-political context of this study, I now recognise the journey through which individuals with LD have been through to arrive at a less negative term that is widely used when referring to this population. Furthermore, to align myself more with the participants who are taking part in this study and have a shared language with them, I feel it is more appropriate to use the term 'learning disability'. I expect that if I continue to employ the term ID, it may position me further 'outside' and may have a negative impact on the relationship between myself and the participants. I want to be mindful of any power differences between myself and any further participants that take part, and minimise where possible.

Appendix D - Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Title

Suicidality in intellectual disability populations: A qualitative exploration of the perceptions and experiences of professionals.

An invitation to participate in a research study

I would like to invite you to take part in a research study which is being undertaken as part of a professional doctorate in clinical psychology at the University of Essex. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?

To date, limited research has been conducted into the experiences of suicidality, which includes suicidal thoughts, ideations and attempts, within intellectual disability populations. The aim of this research study is to get a better understanding of suicide and suicide related behaviours as they present within this population. The study aims to expand the current knowledge base regarding the perceptions and experiences of clinicians working across intellectual disability services in understanding, managing and accessing suicidality in clinical practice. Research findings are expected to have an impact on current practice around screening and managing suicidal risk in intellectual and learning disability populations. This knowledge can help services identify current service needs and will be of value to individuals with intellectual disabilities experiencing suicidal related thoughts and behaviours.

Do I have to take part?

Participation is voluntary, and it is entirely your decision whether or not you wish to take part in this research study. If you do decide to participate, you will be asked to provide written consent. You are free to withdraw at any time prior to or during the interview, without giving a reason. Withdrawal will have no impact on your current or future employment.

What will happen to me if I take part?

Participation would involve meeting principal researcher, Tara Flynn, for approximately an hour, at time and place that is convenient for you. This could be conducted on video using MS Teams or at your workplace. The meeting will involve us having a conversation about your experiences of assessing, managing and supporting individuals with intellectual disabilities experiencing suicidal thoughts and behaviours in your clinical practice. Please note the focus of this project will not be to evaluate the individual/services clinical practice and is only interested in experiences of suicidality as it occurs in clinical practice. With your permission the conversation will be audio recorded which will form the data for the research study.

How will we use information about you?
We will need to use information about you for this research project. This information will include your initials, contact details, occupation and time spent working in ID services as well as a transcript of our discussion. 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. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?
You can stop being part of the study at any time, without giving a reason, up until analysis of the study has commenced, after which withdrawal will no longer be possible. In the instance of your withdrawal from the study your audio recordings and transcripts would be destroyed.
We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?
You can find out more about how we use your information

- by asking one of the research team
- by sending an email to the principal researcher or project supervisor on the contact details below

What are the possible benefits of taking part?

We anticipate that it could be interesting for you to talk about your experiences. By sharing your experience(s) you will be providing valuable information that will be helpful to other people who are supporting individual with intellectual disabilities who may be experiencing suicidal thoughts or behaviours. It is anticipated that this information will provide insight into the experiences of suicidality for this population, of which, little is known. Such may impact what support is needed to help services when encountering this in clinical practice.

What are the possible disadvantages and risks of taking part?

Talking about suicidal thoughts and behaviours experienced by those you are supporting may be difficult and uncomfortable. If you feel that discussing your previous experiences will cause you distress, you may want to consider not participating. Should you decide to participate you will be required to make a plan with the researcher about how best to support you in the event that you do become distressed throughout the interview. Please note the focus of this project will not be to evaluate the service/individual's clinical practice and is only interested in an individual's experiences of suicidality as it occurs in clinical practice. You should also note that you do not have to talk about anything you do not want to.

Will my taking part in the study be kept confidential?

Yes. Ethical and legal policies and procedures will be followed throughout, and all personal information will be handled in confidence. Electronic data will be encrypted, and password protected, and paper files and audio files will be kept in a locked filing cabinet. The audio files will be transcribed (i.e. written out) by the principal researcher and then deleted. All potential information that could identity you (or people mentioned by you) will be removed so that no-one could be identified. Only the researcher, supervisors and examiners will have access to the transcribed material.

The researcher will only break confidentiality following her meeting with you in the unlikely event that she has very serious concerns about your safety or the safety of others. If this is the case, the researcher will discuss this with you where possible.

What will happen if I no longer want to carry on with the study?

You can let the researcher know via the contact details below if you no longer want to carry on with the study. You will be able to withdraw from the study at any stage up until analysis of study has commenced, after which withdrawal will no longer be possible. In the instance of your withdrawal from the study your audio recordings and transcripts would be destroyed.

What if there is a problem?

Any issues that arise will be addressed. If you require support and/or have any concerns, please do not hesitate to discuss with the researcher. If you have concerns that you do not wish to discuss with the researcher, please contact: Dr Alison Spencer, thesis supervisor: as16018@essex.ac.uk

If you remain unhappy and wish to complain formally, you can do this by contacting the University of Essex Research Governance and Planning Manager, Sarah Manning-Press (sarahm@essex.ac.uk).

What will happen to the results of the study?

The results will be written up for the purpose of a doctoral thesis, journal articles and presentations. The findings will include direct quotes from our discussion, which will be used in reports and publications. You will be offered the opportunity to receive a summary of the results. Any reports or written articles resulting from the study will not reveal the identity of anyone who took part.

Who is organising and funding the research?

The research is organised and funded by the University of Essex, in collaboration with Essex Partnership University NHS Trust

Who has reviewed the study?

This study has been reviewed and given favourable opinion by NHS and University of Essex Research Ethics Committee.

How do I express my interest or ask for further information?

We would greatly appreciate if you could e-mail Tara Flynn on tf21563@essex.ac.uk if you are interested in taking part in this research project.

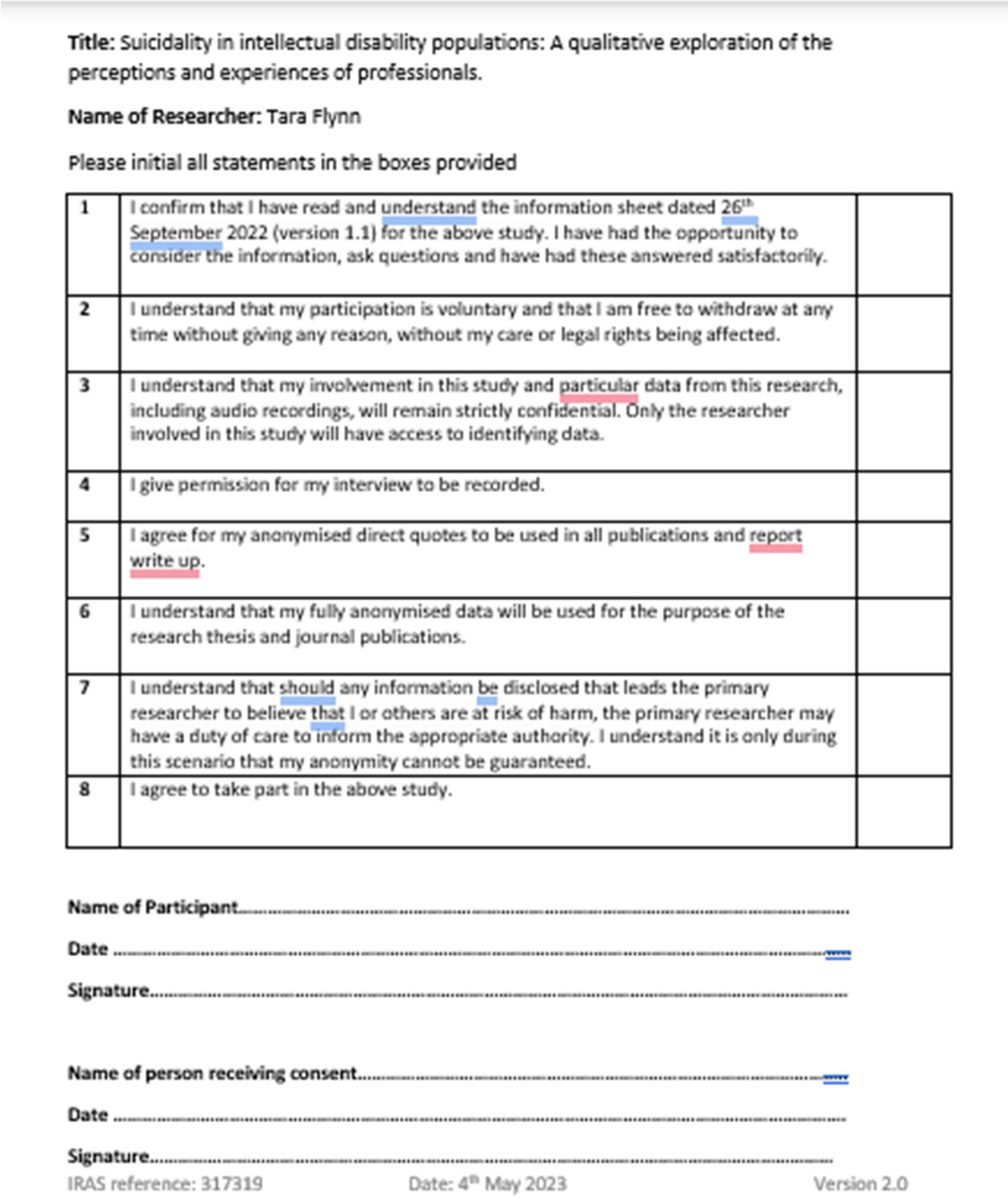
Thank you very much for considering taking part in this study and we look forward to hearing from you.

Yours sincerely,

Tara Flynn
Trainee Clinical Psychologist

Dr. Alison Spencer
Clinical Psychologist & Thesis Supervisor

Appendix E - Consent Form



Title: Suicidality in intellectual disability populations: A qualitative exploration of the perceptions and experiences of professionals.

Name of Researcher: Tara Flynn

Please initial all statements in the boxes provided

1	I confirm that I have read and understand the information sheet dated 26th September 2022 (version 1.1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my care or legal rights being affected.	
3	I understand that my involvement in this study and particular data from this research, including audio recordings, will remain strictly confidential. Only the researcher involved in this study will have access to identifying data.	
4	I give permission for my interview to be recorded.	
5	I agree for my anonymised direct quotes to be used in all publications and report write up.	
6	I understand that my fully anonymised data will be used for the purpose of the research thesis and journal publications.	
7	I understand that should any information be disclosed that leads the primary researcher to believe that I or others are at risk of harm, the primary researcher may have a duty of care to inform the appropriate authority. I understand it is only during this scenario that my anonymity cannot be guaranteed.	
8	I agree to take part in the above study.	

Name of Participant……………………………………………………………………………………………

Date ………

Signature………………………………………………………………………………………………………

Name of person receiving consent………………………………………………………………………

Date ………

Signature………………………………………………………………………………………………………

IRAS reference: 317319 Date: 4th May 2023 Version 2.0

Appendix F – Interview Schedule

Interview topic guide

Demographic information:

-Age
-Gender
-Core profession/Occupation
-Length of years working in LD services

Interview Topic Guide:

-Tell me about your experience of suicidality working in the LD service?
-In your experience how do individuals with LD tend to experience suicidal thoughts or behaviours (this includes thoughts about wanting to end their own life/not wanting to be here and/or attempts to end their own life)?

-How do they express or show this?
-How do you tend to uncover/know about suicidal thoughts in individuals with LD?

-Why do you think individuals with ID experience suicidality (suicidal thoughts/, behaviours, plans, intent)?

-What do you think are the factors that contribute to individuals experiencing such in this poulation?

- What makes an individual more vulnerable to experiencing suicidal thoughts or behaviours?

- How are risk assessments generally conducted in LD services/How do you tend to assess this risk with individuals with LD? What is your experience of assessing suicide risk with individuals with LD?

-What is your experience of discussing suicidality/suicide risk with individuals with LD?

-Are there any challenges or difficulties, you have faced with regards discussing or conducting risk assessments with this population?

-What is your thoughts on capacity in relation to suicide for this population?

-What is it like to for you when an individual expresses/reports suicidal thoughts or behaviours?

-What support is in place for you?

-What do you feel you might need to support you in managing this in your current role?

-Is there anything else that you feel is important to share regarding suicidality in LD population

Appendix G – University of Essex Ethical Approval

Miss Tara Flynn

Health and Social Care

University of Essex

Dear Tara,

Ethics Committee Decision

Application: ETH2223-1596

I am pleased to inform you that the research proposal entitled "Suicidality in intellectual disability populations: A qualitative exploration of the perceptions and experiences of professionals." has been reviewed on behalf of the Ethics Sub Committee 2, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following **conditions**:

Extensions and Amendments:

If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in ERAMS for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

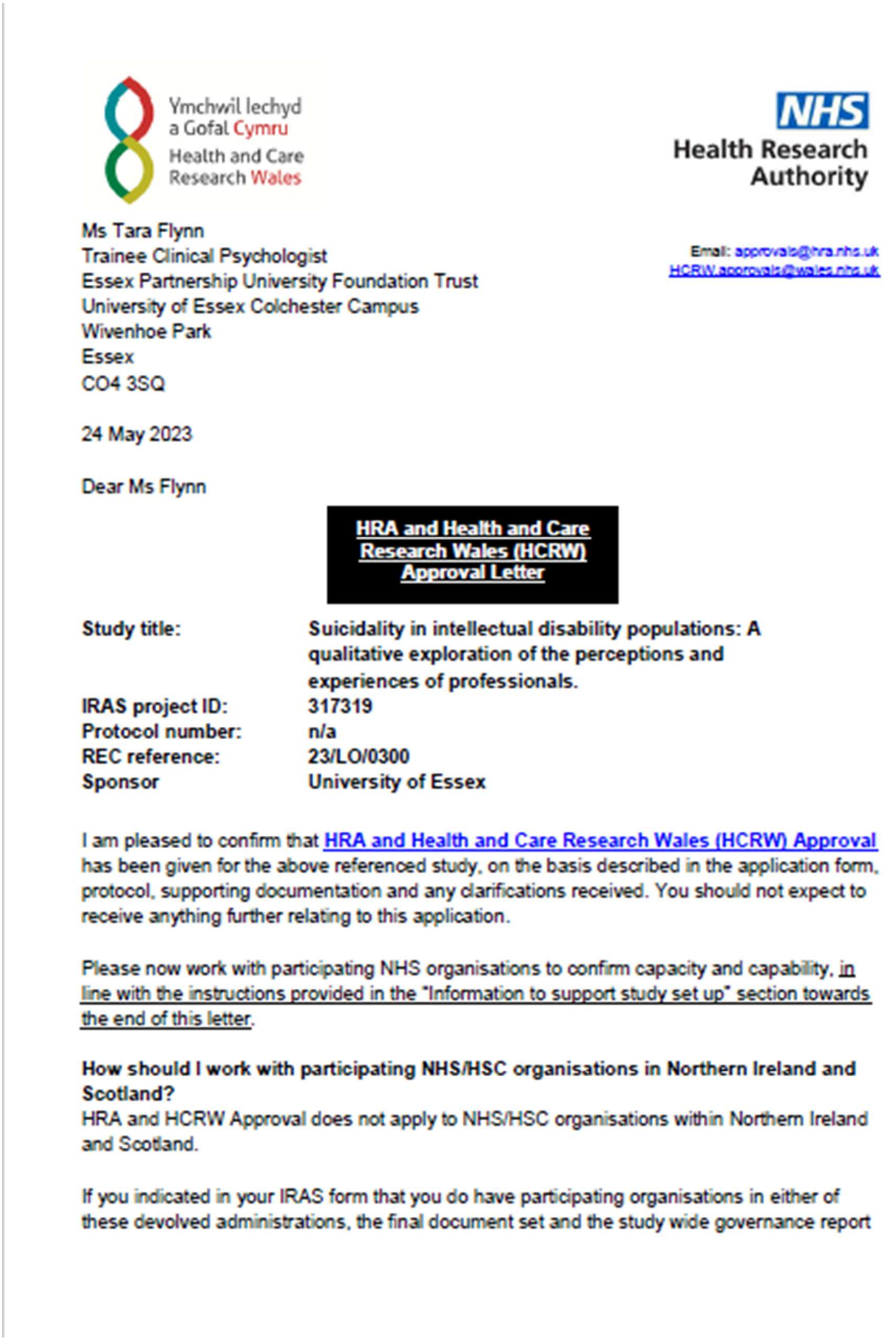
Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of change when planning your research. You will be kept informed if there are any changes in the University guidelines.

Yours sincerely,

Aaron Wyllie

Appendix H – NHS/RHA Ethical Approval



Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

Ms Tara Flynn
Trainee Clinical Psychologist
Essex Partnership University Foundation Trust
University of Essex Colchester Campus
Wivenhoe Park
Essex
CO4 3SQ

24 May 2023

Dear Ms Flynn

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Suicidality in intellectual disability populations: A qualitative exploration of the perceptions and experiences of professionals.**
IRAS project ID:	**317319**
Protocol number:	**n/a**
REC reference:	**23/LO/0300**
Sponsor	**University of Essex**

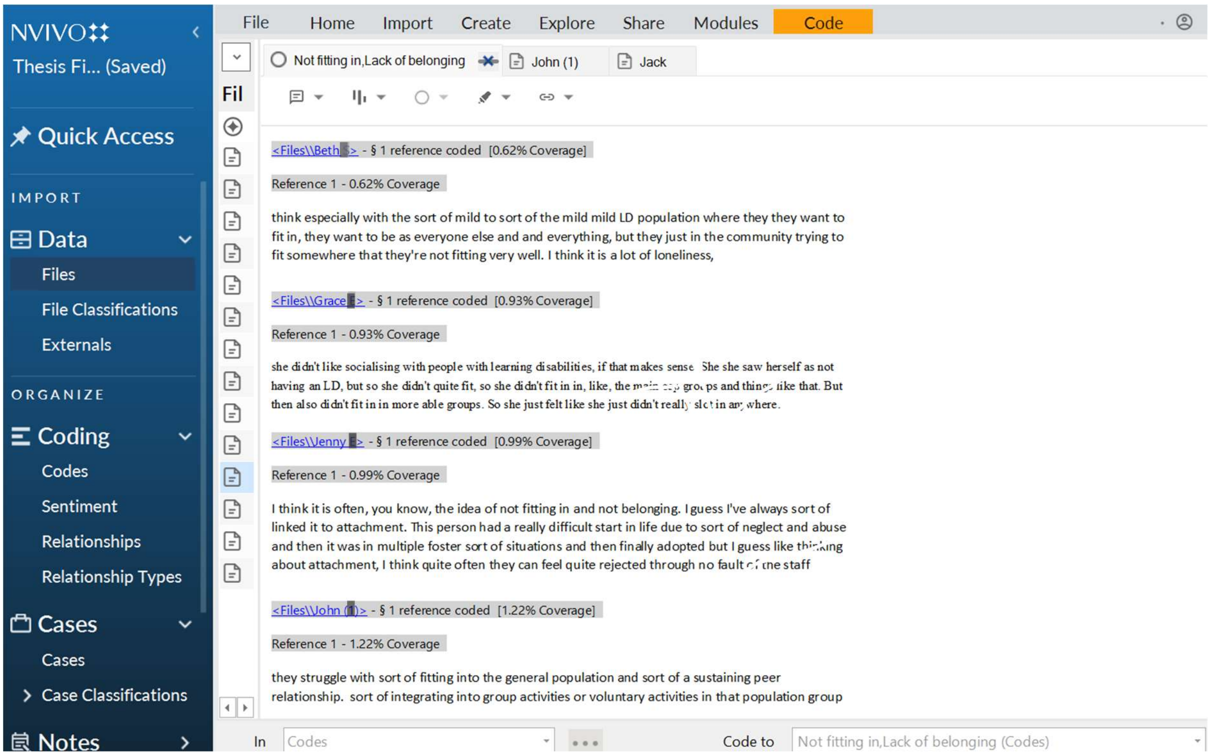
I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

Appendix I – Example of initial coding using NVIVO



<Files\\Beth [redacted]> - § 1 reference coded [0.62% Coverage]

Reference 1 - 0.62% Coverage

think especially with the sort of mild to sort of the mild mild LD population where they they want to fit in, they want to be as everyone else and and everything, but they just in the community trying to fit somewhere that they're not fitting very well. I think it is a lot of loneliness,

<Files\\Grace [redacted]> - § 1 reference coded [0.93% Coverage]

Reference 1 - 0.93% Coverage

she didn't like socialising with people with learning disabilities, if that makes sense She she saw herself as not having an LD, but so she didn't quite fit, so she didn't fit in in, like, the main [illegible] groups and things like that. But then also didn't fit in in more able groups. So she just felt like she just didn't really slot in anywhere.

<Files\\Jenny [redacted]> - § 1 reference coded [0.99% Coverage]

Reference 1 - 0.99% Coverage

I think it is often, you know, the idea of not fitting in and not belonging. I guess I've always sort of linked it to attachment. This person had a really difficult start in life due to sort of neglect and abuse and then it was in multiple foster sort of situations and then finally adopted but I guess like thinking about attachment, I think quite often they can feel quite rejected through no fault of the staff

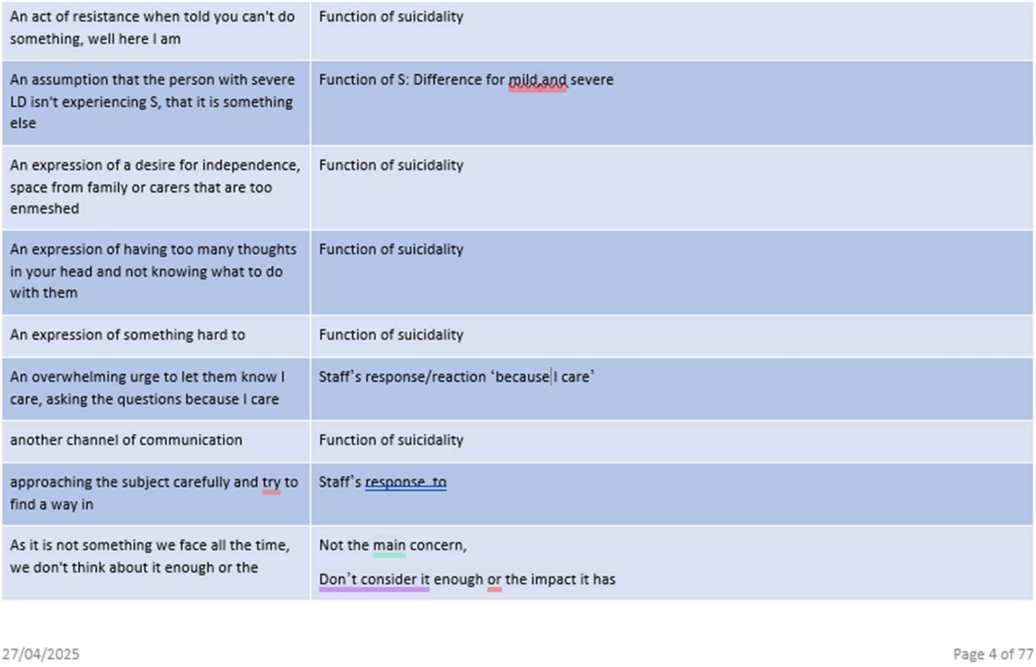
<Files\\John ([redacted])> - § 1 reference coded [1.22% Coverage]

Reference 1 - 1.22% Coverage

they struggle with sort of fitting into the general population and sort of a sustaining peer relationship. sort of integrating into group activities or voluntary activities in that population group

Appendix J – Refining and grouping codes

Example of code classification, grouping and refinement process extracted from Nvivo



An act of resistance when told you can't do something, well here I am	Function of suicidality
An assumption that the person with severe LD isn't experiencing S, that it is something else	Function of S: Difference for mild and severe
An expression of a desire for independence, space from family or carers that are too enmeshed	Function of suicidality
An expression of having too many thoughts in your head and not knowing what to do with them	Function of suicidality
An expression of something hard to	Function of suicidality
An overwhelming urge to let them know I care, asking the questions because I care	Staff's response/reaction 'because I care'
another channel of communication	Function of suicidality
approaching the subject carefully and try to find a way in	Staff's response to
As it is not something we face all the time, we don't think about it enough or the	Not the main concern, Don't consider it enough or the impact it has

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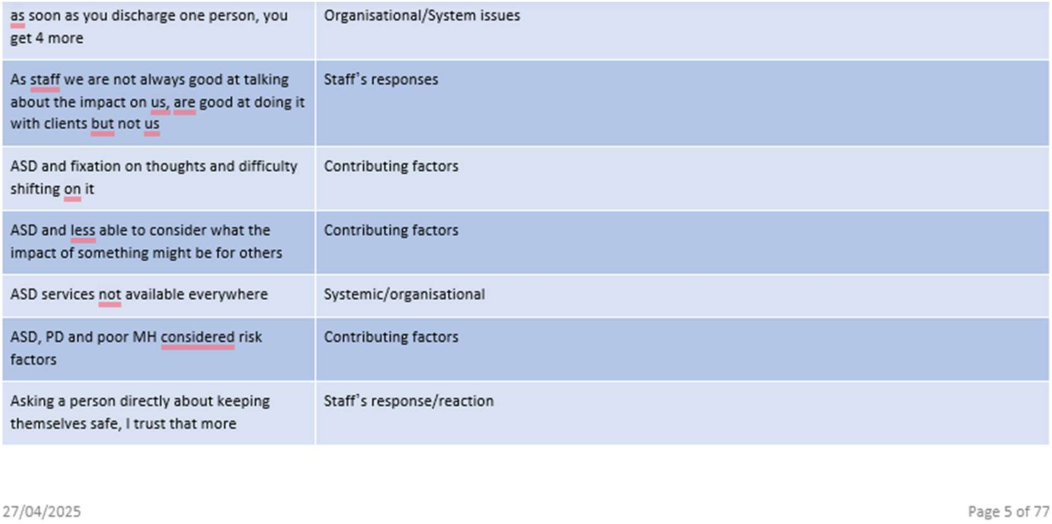

as soon as you discharge one person, you get 4 more	Organisational/System issues
As staff we are not always good at talking about the impact on us, are good at doing it with clients but not us	Staff's responses
ASD and fixation on thoughts and difficulty shifting on it	Contributing factors
ASD and less able to consider what the impact of something might be for others	Contributing factors
ASD services not available everywhere	Systemic/organisational
ASD, PD and poor MH considered risk factors	Contributing factors
Asking a person directly about keeping themselves safe, I trust that more	Staff's response/reaction

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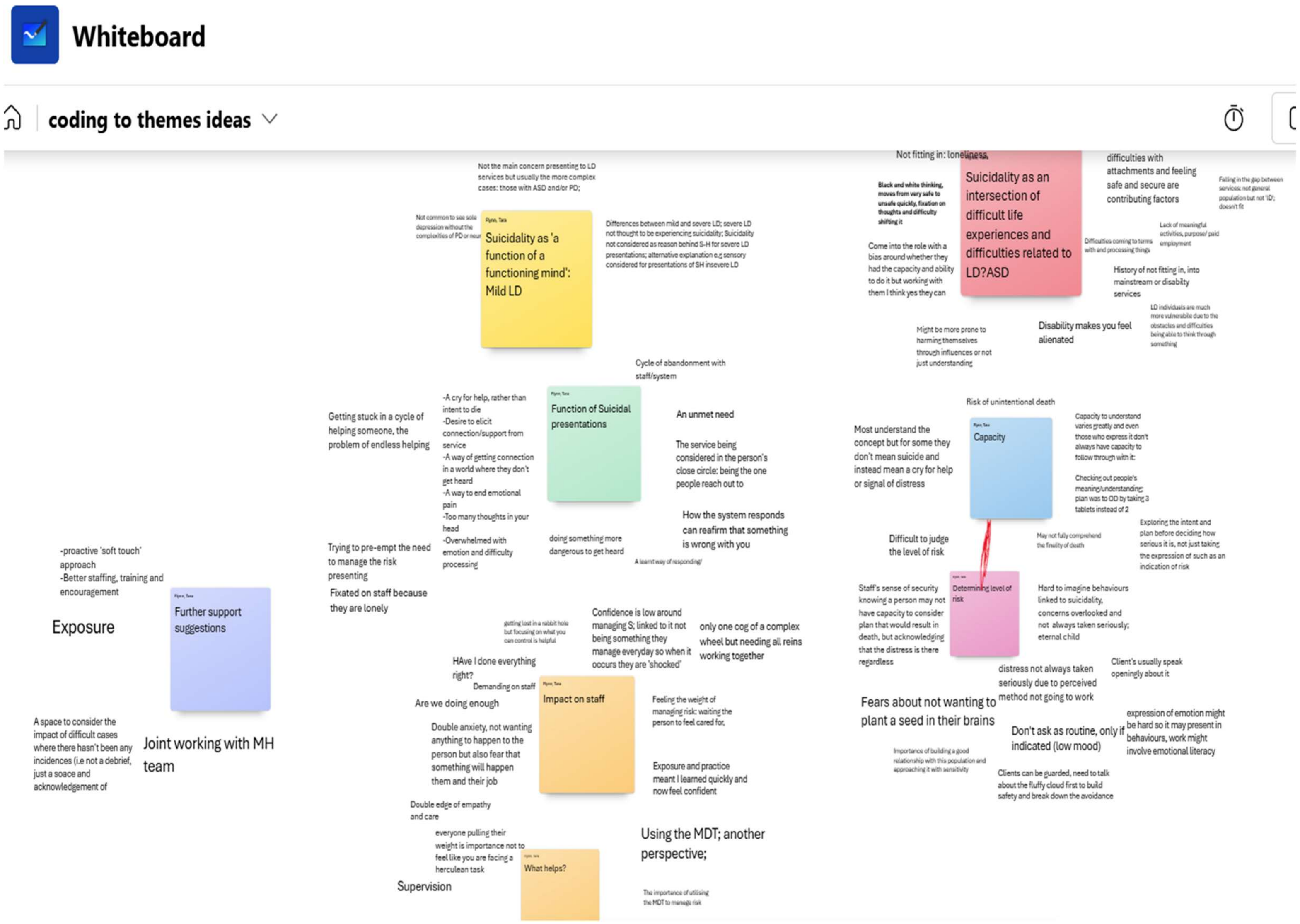
Appendix K – Mind map reflecting the process of initial coding to theme development



Suicidality as 'a function of a functioning mind': Mild LD

Not the main concern presenting to LD services but usually the more complex cases: those with ASD and/or PD;

Not common to see sole depression without the complexities of PD or neur

Differences between mild and severe LD; severe LD not thought to be experiencing suicidality; Suicidality not considered as reason behind S-H for severe LD presentations; alternative explanation e.g sensory considered for presentations of SH insevere LD

Suicidality as an intersection of difficult life experiences and difficulties related to LD?ASD

Not fitting in: loneliness,

Black and white thinking, moves from very safe to unsafe quickly, fixation on thoughts and difficulty shifting it

Come into the role with a bias around whether they had the capacity and ability to do it but working with them I think yes they can

difficulties with attachments and feeling safe and secure are contributing factors

Falling in the gap between services: not general population but not 'ID'; doesn't fit

Difficulties coming to terms with and processing things

Lack of meaningful activities, purpose/ paid employment

History of not fitting in, into mainstream or disabilty services

LD individuals are much more vulnerable due to the obstacles and difficulties being able to think through something

Might be more prone to harming themselves through influences or not just understanding

Disability makes you feel alienated

Function of Suicidal presentations

Cycle of abandonment with staff/system

Getting stuck in a cycle of helping someone, the problem of endless helping

-A cry for help, rather than intent to die
-Desire to elicit connection/support from service
-A way of getting connection in a world where they don't get heard
-A way to end emotional pain
-Too many thoughts in your head
-Overwhelmed with emotion and difficulty processing

An unmet need

The service being considered in the person's close circle: being the one people reach out to

How the system responds can reafirm that something is wrong with you

doing something more dangerous to get heard

A learnt way of responding/

Trying to pre-empt the need to manage the risk presenting

Fixated on staff because they are lonely

Capacity

Risk of unintentional death

Most understand the concept but for some they don't mean suicide and instead mean a cry for help or signal of distress

Capacity to understand varies greatly and even those who express it don't always have capacity to follow through with it:

Checking out people's meaning/understanding; plan was to OD by taking 3 tablets instead of 2

Exploring the intent and plan before deciding how serious it is, not just taking the expression of such as an indication of risk

May not fully comprehend the finality of death

Difficult to judge the level of risk

Determining level of risk

Staff's sense of security knowing a person may not have capacity to consider plan that would result in death, but acknowledging that the distress is there regardless

Hard to imagine behaviours linked to suicidality, concerns overlooked and not always taken seriously; eternal child

distress not always taken seriously due to perceived method not going to work

Client's usually speak openingly about it

Fears about not wanting to plant a seed in their brains

Don't ask as routine, only if indicated (low mood)

expression of emotion might be hard so it may present in behaviours, work might involve emotional literacy

Importance of building a good relationship with this population and approaching it with sensitivity

Clients can be guarded, need to talk about the fluffy cloud first to build safety and break down the avoidance

Impact on staff

getting lost in a rabbit hole but focusing on what you can control is helpful

Confidence is low around managing S; linked to it not being something they manage everyday so when it occurs they are 'shocked'

only one cog of a complex wheel but needing all reins working together

HAve I done everything right?

Demanding on staff

Are we doing enough

Double anxiety, not wanting anything to happen to the person but also fear that something will happen them and their job

Feeling the weight of managing risk: waiting the person to feel cared for,

Exposure and practice meant I learned quickly and now feel confident

Double edge of empathy and care

What helps?

everyone pulling their weight is importance not to feel like you are facing a herculean task

Supervision

Using the MDT; another perspective;

The importance of utilising the MDT to manage risk

Further support suggestions

-proactive 'soft touch' approach
-Better staffing, training and encouragement

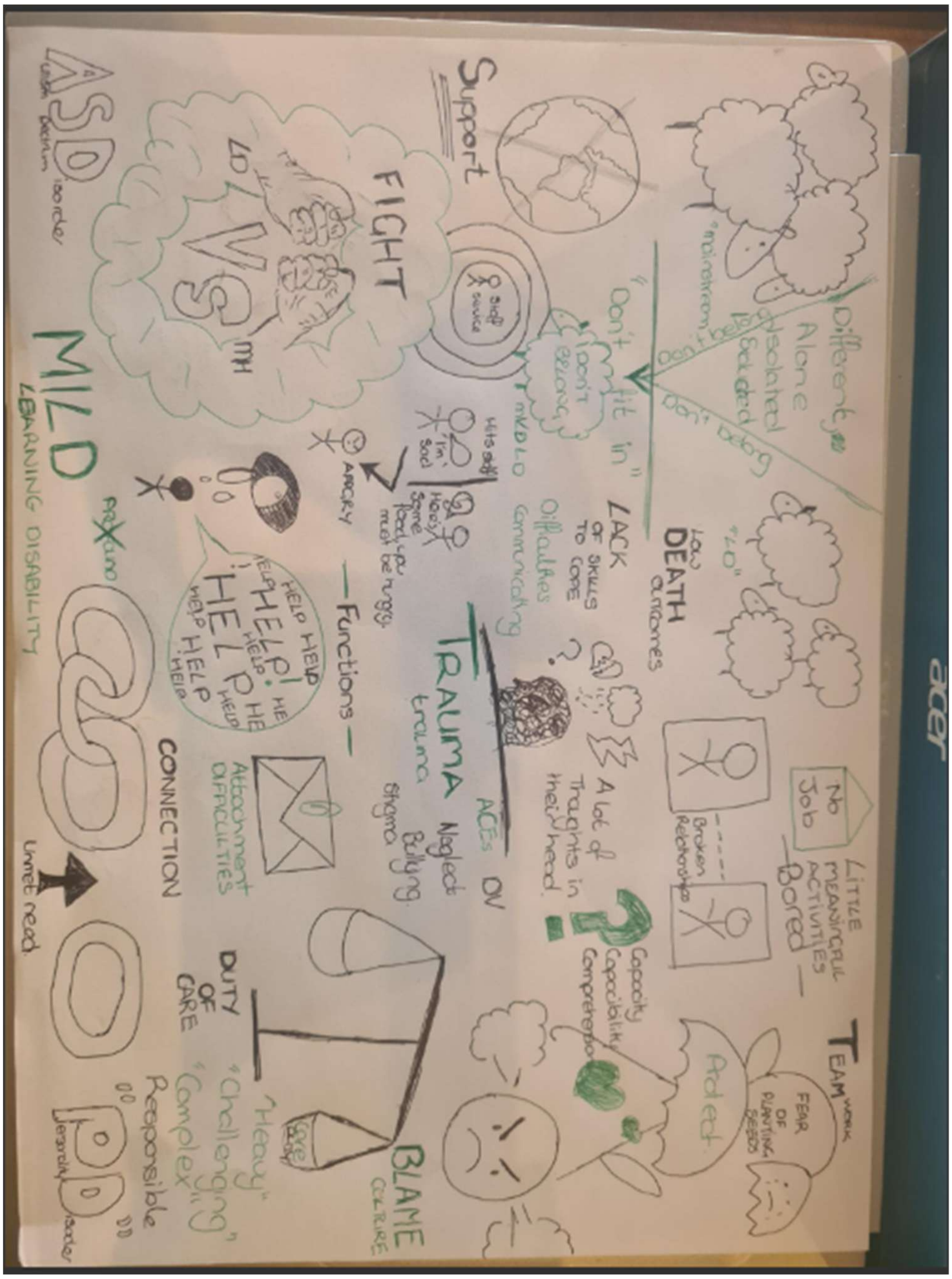
Exposure

A space to consider the impact of difficult cases where there hasn't been any incidences (i.e not a debrief, just a soace and acknowledgement of

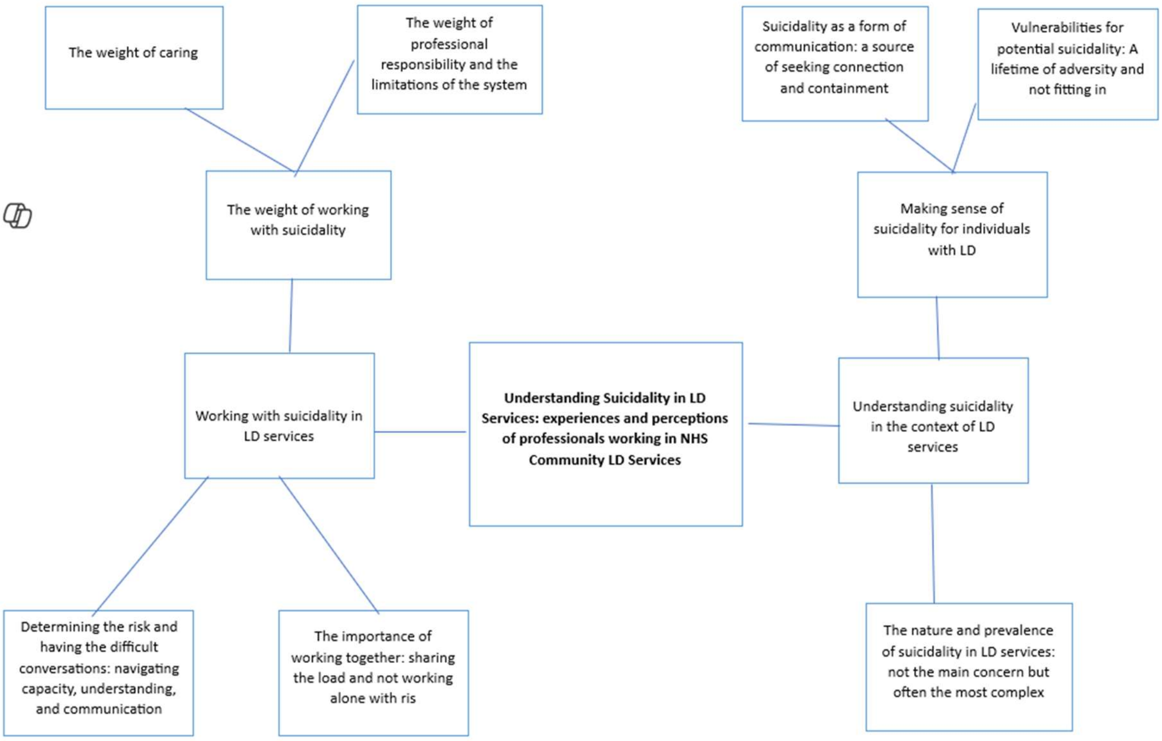
Joint working with MH team

Appendix L – Process of RTA: researcher's reflections

Reflections following grouping of codes to further refine the initial themes



Appendix M – Final Dynamic Thematic map



Appendix N– CASP review of current study

CASP (2018) Critical Appraisal of the current study

CASP Tool criteria Yes = criteria met No = criteria not met ? = unclear/unable to tell	**Criteria Met:**	**Comments outlining how the criteria have been met:**
1. Is there a clear statement of the aims of the research?	Yes	This study aimed to explore the experiences and perspectives of professionals with regards suicidality in LD populations as it presents in NHS Community LD services. The research questions and aims were clearly outlined in chapter one, alongside a rationale for the study.
2. Is a qualitative methodology appropriate?	Yes	Given the explorative nature of the research and the research aims, a qualitative methodology appeared most appropriate. The methodology enabled in-depth insights into the experiences of professionals working in LD services to be explored that would not be achieved through quantitative methods alone.
3. Was the research design appropriate to address the aims of the research?	Yes	Limited research exists regarding the experiences of professionals working with suicidality in LD populations. In addition to the relatively limited and poor-quality research that is available regarding understanding of suicidality in this population, the literature review confirmed that no research has been conducted in the UK exploring the perspectives and experience of staff regarding this complex and nuance topic in the LD service. A qualitative research design, and the use of semi-structured interviews, which aligned with the researcher's critical realist epistemological position, appeared to be a good fit to address the aims of the research.
4. Was the recruitment strategy appropriate to the aims of the research?	Yes	The use of both purposive and snowball sampling was effective in meeting the aims of the research. More explicitly, employing purposively sampling ensured that participants had some experience of working with suicidality to be able to provide relevant and nuanced insights into the topic of suicidality (Hassan, 2024). Combining this with snowball sampling increased the sample pool of interested participants who took part in the study, which may not have

		happened without signposting from others who had completed it.
5. Was the data collected in a way that addressed the research issue?	Yes	Data was collected using semi-structured interviews which followed a flexible topic guide. This enabled the researcher to ensure the topic was covered but with an approach that was flexible enough to ensure the participant was able to bring their own experiences and perspectives, providing rich and in-depth insights into the topic in question. In addition, each interview was conducted online and at a time that was convenient to the participant to aid data collection, which is crucial in the context of busy, over stretched NHS services.
6. Has the relationship between the researcher and participants been adequately considered?	Yes	The researcher commenced this study as an ‘outsider’ but transitioned to a more ‘insider’ position (Dwyer & Buckle, 2009) part way through the study taking up a final year clinical psychology training placement within the LD service. For the majority of participants, the researcher engaged with the interviews from an outsider position, but for some they were considered an ‘insider’. Evidentially, this may have shaped my relationship to the data and research/ Nevertheless the research engaged in a reflective process throughout the research, using a reflective journal to identify, consider and bracket any potential bias.
7. Have ethical issues been taken into consideration?	Yes	Ethical approval was obtained from the HRA and University of Essex ethical committees prior to commencing the study. The researcher also acknowledged the potential distress and need for sensitively to discussing a topic like suicide. In the participant information sheet, participants who felt like this would be a distressing topic for them were asking not to participate. The potential for distress was also outlined at the start of each interview and a plan was agreed with each participant if they became distressed.
8. Was the data analysis sufficiently rigorous?	Yes	A thorough and methodical examination of the data following the dynamic and iterative RTA process, as outlined by Braun & Clarke (2022) to arrive at the initial themes. Two reflective sessions were conducted with participants, providing them an opportunity to corroborate the researcher’s interpretation of the analytical narrative that emerged through the RTA process. This session enabled the

		researcher to develop interpretations and arrive at the final themes, while also ensuring that the themes accurately represented the experiences and perspectives of the participants.
9. Is there a clear statement of findings?	Yes	The findings have been summarised in a brief paragraph in the discussion chapter.
10. How valuable is this research?	Yes	The current research aimed to explore the experiences and perspectives of professionals working in LD services concerning suicidality in the LD population. While much research has been conducted regarding suicidality more generally, understandings of suicidality in LD population remains limited. Furthermore, little is known about the experiences of professional working with suicidality in clinical practice. The findings of the current study provide in depth insights into understandings of suicidality for individuals with LD, alongside the experience of staff in assessing and managing the risk in clinical practice. It is anticipated that the findings will increase awareness of recognising suicidality in the LD population, which could have significant impact on outcomes and experience of care. The findings could also support developments towards more effective ways of working with suicidality and identify factors to consider when working with individuals with LD presenting with suicidality.