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RESEARCH ARTICLE

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Mental health practitioners' views on assessing suicide risk in the emergency department: navigating a challenging assessment process.

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ABSTRACT

Background: The Emergency Department (ED) is a key setting for suicide risk assessments. In the UK, mental health professionals (MHPs) in psychiatry liaison teams assess suicide risk.

Aim: This study aimed to explore how MHPs in EDs experience and approach the assessment of suicide risk for people presenting for suicidal ideation and/or self-harm.

Methods: We interviewed 22 MHPs from one hospital (England) on their views of conducting psychosocial assessments. Interviews were recorded, transcribed and analysed using inductive thematic analysis.

Results: MHPs described various challenges, summarised in four main areas: the complexity of assessing suicide risk and lack of confidence in some patients/ accounts, the dynamic nature of risk, the impact/barrier of a structured assessment form, and institutional pressures and lack of resources. We identified views and attitudes that delegitimise patients. While such practices at an individual level need to be addressed, we posit this reflects organisational pressures that stifle practitioners' ability to prioritise therapeutic alliance.

Conclusions: It is unsurprising that MHP experience moral injury that can be manifested as amplify biases and compassion fatigue. This calls for changes to support staff striving to make assessments therapeutic and we recommend both top-down and bottom-up initiatives to improve the experiences of MHPs and their patients.

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Suicide; self-harm; risk assessment; legitimacy; Emergency Department (ED)

1. Introduction

Globally, over 720,000 people die by suicide each year (WHO, 2025) and hospital presenting self-harm is one of the highest risk factor for subsequent suicide (Carroll et al., 2014). In England and Wales, over 6000 people took their own lives in 2023, an increase since 2022 and previous years (ONS, 2025). These figures are likely underestimates due to underreporting and they do not reflect the broader impact of suicide on the estimated 135 people affected by each suicide (Cerel et al., 2019).

When people present to Emergency Departments (EDs) with self-harm or suicidal ideation, clinical guidelines recommend mental health professionals (MHPs) in liaison psychiatry teams conduct psychosocial assessments to assess risk to themselves and others and further needs (Carroll et al, 2016).

However, people with lived experience, MHPs and researcher have raised concerns about the effectiveness and therapeutic value of these assessments (Kapur et al., 2008; Marzetti et al., 2022). There is little predictive value in categorising suicide risk (Steeg et al., 2018) and nearly 90% of people who died by suicide in the UK were assessed as low risk of suicide in their final contact with services (Graney et al., 2020).

Despite these limitations, risk categorisation remains embedded in practice possibly due to institutional pressure surrounding legal liability (Sabe et al., 2021). MHPs face the threat of litigation following a patient's suicide, which shifts emphasis on documentation of risk assessment as a means of protecting MHPs (Pinals, 2019).

This overemphasis on risk has been criticised as counterproductive to therapeutic engagement (Hawton et al., 2022). Acknowledging such criticism, UK national

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guidelines (NICE, 2022) and policy reports (NHS England, 2024) recommend against risk assessment tools, instead promoting a therapeutic assessment that instils hope and encourage open communication. Research highlights that such approaches are more likely to facilitate honest disclosure and foster trust (O'Keeffe et al., 2021; Xanthopoulou et al., 2021). Nonetheless, many suicide prevention policies continue to narrowly focus on immediate risk instead of alleviating distress or identifying long-term support, reinforcing a narrow approach to care (Marzetti et al., 2022). The aim of this study was to explore how MHPs in EDs experience and approach the assessment of suicide risk.

2. Methods

Data were collected as part of a mixed-methods study which explored the quality of conversations about suicide risk between patients and MHPs in ED psychosocial assessments from one ED liaison psychiatry team in a rural area of England. The study obtained ethical approval from the London-Central Research Ethics Committee (17/LO/1234). This paper will focus on interviews with MHPs who participated in the mixed-methods study. Semi-structured interviews were conducted via telephone or in-person at their workplace, between September 2018 and April 2019. MHPs were interviewed by two researchers (PX and one research assistant). The interview guide was developed with MHPs and a lived experience researcher, and explored MHPs' experiences and perspectives on conducting psychosocial assessments in the ED, with specific questions on assessment of suicide risk.

The interviews were audio-recorded, transcribed, anonymised and analysed thematically. The analysis included reading all transcripts and familiarisation with the data by all authors. Following this, transcripts were coded line-by-line by PX (postdoctoral researcher) and MS (postgraduate researcher) using the qualitative software NVivo12. Development of the coding scheme was iterative and inductive thematic analysis was conducted in bi-weekly (PX and MS) and monthly (PX, MS and RM) meetings over a period of one year, to identify patterns by generating codes and categorising them into sub-themes and themes (Braun & Clarke, 2006).

Patient and Public Involvement: The MHP interview guide (Figure 1), MHP consent forms and information sheets were developed in a focus group with MHPs. A lived experience researcher was involved at all stages of the study.

3. Results

Twenty-two of 32 (70%) participating MHPs with diverse professional roles were interviewed (see Table 1). MHPs views emphasised a focus on risk categorisation and how they evidenced low risk. Identification of psychopathology overshadowed contextual and social contributors to suicidality. They considered the assessments overall ineffective in predicting future risk of suicide and planning care as often futile because of strained resources for onward care. MHPs also suggested that the assessment structure limits exploration of suicidal thoughts and therapeutic assessments. MHPs address this by circumventing the assessment structure. Table 2 presents the themes/subthemes.

Theme 1. The complexity of assessing risk: interpreting intent, evidence and patient credibility

1.1. Patients with "low level" distress and without suicidal intent deemed not appropriate for ED

MHPs viewed distress and suicidal ideation without explicit intent as invalid reasons for a psychosocial assessment. They expressed frustration in seeing people with anxiety or distress and stated they should not be attending the ED: "people showing up to A&E with mental health needs but not the kind of liaison mental health needs" (MHP01, Locum Psychiatrist). They stated that "suicidal thoughts are actually part

1. How do you find working within the Liaison Psychiatry Service?
2. What do you think about the assessment process?
3. What is the main objective of the assessment?
4. When you ask people about suicide, where are you drawing your knowledge and experience from?
5. How confident do you feel in how to ask questions about suicidal ideation?
6. Do you feel skilled in how to ask questions about suicidal plans? Why?
7. Do you feel confident about the information you're getting from patients?
8. When assessing a patient, do your fellow MHPs evaluate risk the same way as you? What are the differences if any, assessing people in ED compared to e.g. an Acute Medical Unit or other settings?

Figure 1. Interview guide questions.

Table 1. Participant characteristics.

Participant characteristics	N = 22
Age	Average 38 years (range 24–59, SD = 11.5)
Gender	Female: 13; Male: 9
Professional Role	• Mental Health Nurse (6) • F1 Doctor (5) • Senior mental health professional (3) • Consultant Psychiatrist (2) • F2 Doctor (2) • Occupational Therapist (2) • Social Worker (2)
Years in Liaison Psychiatry	Average 3 years (range 0.5-14, SD = 3.3)
Years in Mental Health	Average 11 years (range 0.5-28, SD = 9.3)
Ethnicity	• White British (19) • White Other (1) • African (1) • Indian (1)

F1 = Foundation Year 1, F2= Foundation Year 2.

Table 2. Themes and sub-themes.

Themes	Sub-themes
1. The complexity of assessing risk: interpreting intent, evidence and patient credibility	1. Patients with 'low level' distress and without suicidal intent deemed not appropriate for ED 2. Protective factors or pushing for discharge? 3. "Be credulous and suspicious at the same time" about the patient's account of suicidal intent 4. "Severe" self-harm is taken seriously
2. Underestimating and undermining mental health presentations: the impact of stigma, frequent attendance and diagnosis of personality disorder	1. Approach the assessment differently and place more emphasis on what is in notes before assessment 2. Underestimating seriousness of suicide risk in people who attend frequently and/or those with a diagnosis of personality disorder 3. Legitimacy and stigma around mental health presentations in the ED: accepting the patient's account and moving beyond the risk assessment
3. Variability and the transient nature of suicide risk	1. Variability in how MHPs assess risk and difficulty of predicting risk 2. Risk assessment does not capture the dynamic nature of risk
4. Structured risk assessment, Institutional pressures, and lack of community services barrier to therapeutic assessment and follow-up care	1. The assessment template is for the institution and undermines therapeutic potential 2. Pressure to discharge and lack of resources

and parcel of mental health distress that anyone can experience" (MHP07, Senior MHP) and not necessarily considered as risk of suicide. These people were judged to have a low suicide risk and their distress downgraded:

> people will just come in and say 'I'm feeling in distress and I want to speak to somebody'… Like a drop-in counselling service… we don't have the ability just to say 'actually, you're feeling a bit worried, how about doing this' and then goodbye…I'm worried that more people are starting to come to A&E with very low-level mental health problems. (MHP07, Senior MHP)

Suicidal intent was an important consideration for assessing risk. Those presenting with self-harm without suicidal intent were categorised separately from those with suicidal intent:

> There are others who will self-harm with the intention of self-harm… but not with the intention of ending their life … they're harming themselves in terms of, of relieving stress, it's their means of coping, and they have no intentions of ending their life. (MHP02, Senior MHP)

Suicidal risk for these individuals were often categorised as low and if they died by suicide it would be considered accidental: "[some] can have high risk of self-harm and they probably won't kill themselves, if they did it would be very much accidental so they could be high risk with that but be a very low risk of suicide" (MHP08, Senior MHP).

1.2. Protective factors or pushing for discharge?

MHPs viewed presentations without specific intent as lower risk and would attempt to shift a patient's negative outlook to a positive framing during the assessment: "looking at what's worked well in the past … not dwelling too much on the negatives, but looking at the positives and the changes that people can make and what a good day basically would look like for that person…there's a tendency to tell us about the problems" (MHP02, Senior MHP).

While such reframing can be supportive, it was also cited as evidence for discharge decisions: "evidence a shift in thinking [in the patient during the assessment], the evidence [of] is it safe to go home?" (MHP11, Senior MHP).

In this way, encouraging a positive outlook could serve dual functions: supporting the patient and reinforcing the decision to discharge. One MHP suggested this can help deter patients from seeking admission "feeding the gloom of the situation and going into [in-patient] hospital, which is what some people want" (MHP07, Senior MHP). In this context, reframing distress in more positive terms can be motivated by aligning patient narratives with decisions to discharge.

However, some MHPs were cautious about encouraging positive perspectives in the psychosocial assessment. They acknowledged it could be perceived as dismissive of the patient's current state: I think [focusing on solutions], we have to be a little careful to jump in because sometimes that can seem to the

person that you're trying to quickly fix, fix things… But, actually, they're not wanting to hear that because of where they're at" (MHP22, Senior MHP).

Others reflected critically that the focus on protective factors serves institutional needs more than therapeutic ones and resisted following this process:

> I find sometimes in the assessments… they're protecting us as professionals rather than having a therapeutic value for the patient… by creating a long assessment that lists all the protective factors sometimes feels like that's more for our benefit to evidence that this persons' safe to go. So, I tend to make a shorter risk statement and spend less time on listing those. (MHP03, Specialty Trainee Doctor)

1.3. "Be credulous and suspicious at the same time" about patient's account of suicidal intent

Several MHPs described not taking patients' accounts of risk at face value. Instead, they assess credibility in light of contextual cues. One MHP explained the challenge lies in "trying to work out how much trust you can place in the person" (MHP31, Foundation Year Doctor). The consultant of the service articulated a "need to be credulous and suspicious at the same time" (MHP04, Consultant Liaison Psychiatrist).

This scepticism was often rooted in concerns that some patients misunderstand or exaggerate risk: "I mean, we get […] people who are, you know, trying to cause anxiety in you by overstating their future risk" (MHP22, Senior MHP). One MHP reflected on a time when a patient assessed as high risk absconded from ED but did not act on suicidal thoughts. This led the MHP to question the authenticity of the patient's initial stated intent: "she got out, but she didn't do anything … 'oh, maybe you're not as committed to ending your life as you think you are'" (MHP31, Foundation Year Doctor).

Patients' account of suicidal intent was weighed against behaviour and context: "for some, yeah you take [their account] at face value and it's a serious risk, but for others you have to look at all supporting evidence" (MHP02, Senior MHP)

Expression of future plans were prioritized over their account, and that some MHPs perceived patients as overstating risk to gain admission. One MHP stated they were "cautious of people who are trying to get psychiatric beds" (MHP11, Senior MHP) and sought to deter such requests.

1.4. "Severe" self-harm is taken seriously

MHPs used observable, physical indicators of self-harm to indicate greater severity. A serious self-harm method like a large overdose was deemed a higher risk of future suicide: "where the method [of self-harm] had been significant, I think particularly risky" (MHP22, Senior MHP). Patients treated in the acute medical unit (AMU) for self-harm were therefore viewed as having greater risk of taking their lives:

> In AMU setting someone is already engaged in self-harm to the point that they require treatment. If you are looking at the journey of self-harm, they have got closer to ending their lives than potentially the person that we see in ED [where the physical harm is less]. (MHP11, Senior MHP)

Theme 2: Underestimating and undermining mental health presentations: the impact of stigma, frequent attendance and diagnosis of personality disorder

2.1. Approach the assessment differently and place more emphasis on what is in notes before assessment

MHPs described approaching assessments differently for people who attend ED frequently and/or have a diagnosis of personality disorders (PD). There was notable scepticism towards these patients' accounts. One MHP noted: "although they're saying they're going to go in front of a train, I know them" (MHP21, Mental Health Nurse), indicating the influence of prior interactions on assessment of suicide risk. The PD diagnosis label diminished the perceived credibility of the patient's account: "If I hadn't known the [PD] history then I would've placed more confidence in what they were saying than I end up doing" (MHP31, Foundation Year Doctor). MHPs described gathering collateral information and cross-checking statements against documented history to identify inconsistencies.

Most participants, when asked about the main challenges in assessing risk, they emphasised PD as both challenging and routine: "We see a lot of people with personality disorders in our job, and for those, having suicidal thoughts can be very much a part of that condition." (MHP12, Senior MHP). They also acknowledged that negative assumptions about patients with PD diagnoses had an impact on whether referrals from these patients were accepted: "people who might have personality disorder diagnosis […] We're saying 'because you self-harm therefore you can't come" (MHP09, Mental Health Nurse).

2.2. Underestimating seriousness of suicide risk in people who attend frequently and/or those with a diagnosis of personality disorder

One MHP reported that their assessment of suicide risk varied considerably for those who are known to them and people who attend the ED for the first time: "there is different types of risk even if you just look at frequent attenders and people who've come for the first time their risk is completely different" (MHP29, Foundation Year Doctor). Self-harming behaviours of patients with PD diagnoses, who were 'frequent attenders' were described as "superficial" and lacking genuine suicidal intent:

> PD patients who have got a pattern of presenting with suicidal ideation but have never had intent, never had plans….They self-harm but quite superficially and it is along the lines of, we know they are going to go home and take a small overdose, but we know it is going to be a small overdose and they will self-present to hospital. (MHP15, Foundation Year Doctor)

This reflects how perceived familiarity and diagnostic assumptions could lead to underestimation of risk.

2.3. Legitimacy and stigma around mental health presentations in the ED: accepting the patient's account and moving beyond the risk assessment

Many MHPs recognised the stigma surrounding mental health presentations. They reflected that these patients are deprioritised adding to feelings of exclusion in EDs which can worsen symptoms. One MHP stated:

> there is stigma against mental health [and] feel these people shouldn't be in the ED. Or leaving it until it gets to a crisis-point to present, because you'd think 'I don't want to be seen in hospital or in ED, because 'you don't want me here.' (MHP14, Foundation Year Doctor)

In contrast, several MHPs described efforts to address the person's needs rather than merely assessing risk: "from the patient's perspective the most important thing is […] the opportunity for a therapeutic interaction" (MHP03, Specialty Trainee Doctor). Others emphasised hearing the patient's story: "these people that have turned up wanting help. Usually that's a good sign that they're going to tell you how they really feel" (MHP28, Foundation Year Doctor).

Some MHPs explicitly rejected the idea that assessments should be geared towards discharge: "none of us come into these jobs to go 'alright go home'" (MHP13, Clinical Practice Lead). These MHPs strived to avoid preconceived, stigmatising notions of patients: "not to assume that you know, um, answers because everybody's experience is different […] non-judgemental way of working and talking to someone is what can help to produce a better quality conversation" (MHP12, Senior MHP).

Theme 3: Variability and the transient nature of suicide risk

3.1. Variability in how MHPs assess risk and difficulty of predicting risk

MHPs reported variability in how they assess risk, noting that one MHP might categorise a patient as low risk while another might consider them high risk. MHPs attributed this to differences to varying perspectives on risk: "some of us are probably more positive risk takers than others or [some are] more risk averse" (MHP13, Clinical Practice Lead). Consequently, many MHPs sought a second opinion: "if I think my colleague's missed something or maybe he's not appreciating some aspect of the assessment, then I'll make him aware" (MHP02, Senior MHP). One MHP described changing their risk categorisation after a more experienced colleague identified a previously overlooked protective factor: "there have been occasions when I've thought someone might be higher risk and then somebody[else] has picked up on other protective factors and you go, 'Oh, yeah, actually" (MHP19, Senior MHP).

Some MHPs indicated that seeking others' opinions helped share the burden of risk: "Try and ascertain other people's views to see if there is anything that you have missed really. Share the risk basically" (MHP18, Senior MHP).

3.2. Risk assessment does not capture the dynamic nature of risk

MHPs viewed the risk assessment as somewhat arbitrary due to the transient and changeable nature of suicidality. One MHP pointed out "the crisis is on its way down" (MHP02, Senior MHP) even before the assessment begins. The transient nature of suicidal behaviour means the risk level assigned to the patient is not permanent. Thus, MHPs framed the assigned risk level as relevant only to the time the patient was under their care and the immediate aftermath:

> "at the point of the assessment, I feel the risk is pretty accurate" (MHP18, Senior MHP), and that "people don't go out and kill themselves on their way home. So we've probably done an alright risk assessment for the few minutes after our consultation" (MHP31, Foundation Year Doctor).

In contrast, some MHPs find that certain components of risk are "static and are more unlikely to change" that "the assessment is very good at capturing" (MHP03, Specialty Trainee Doctor). They explained that a psychosocial assessment can help arrive at a definitive conclusion about an individual's risk level: "look at the social situation, biological situation, their mental health, research. Chuck all those together and you will have a pretty good idea on what the actual risks of them acting are" (MHP18, Senior MHP).

Theme 4: Structured risk assessment, institutional pressures, and lack of community services are barriers to therapeutic assessment and follow-up care

4.1. The assessment template is for the institution and undermines therapeutic potential

MHPs stated that the primary aim of the assessment is to identify and categorise risk and the structure of the assessment and specific questions included in the template were linked to:

> wider operational policies and then the stuff that comes down from higher up and the management structures and things, like, make it more and more rigid, like we have to ask this question and we have to – and we're now having our targets measured on whether we've talked to them about childhood trauma and now having our targets… makes it more restrictive, rather than having that freedom as experienced MHPs that we can go and assess the situation. (MHP13, Clinical Practice Lead)

They described no scope for alleviating distress during the assessment: "I would like to be able to sit here and say the [focus is on] emotional distress and um exploring that with the person … but the main part I think is we're just really heavily weighted towards risk" (MHP13, Clinical Practice Lead).

While the structure provided a "clear structure for how you're going to talk to someone [and] what information you're going to gather" (MHP12, Senior MHP), some suggested that it felt "boundaried" (MHP09, Mental Health Nurse) and often led to a "one size fits all response" (MHP03, Specialty Trainee Doctor). Many criticised the relevance of the questions and described how they use a checklist of risk indicators, which sometimes turned the assessment into "a bit of a tick-box system" (MHP19, Senior MHP). They stated the sheer number of questions asked made it "quite intense [and] quite tedious" (MHP08, Senior MHP) for patients and the structure stifled conversation: "if you'd just gone through the proforma with him, you might've got a bit stuck" (MHP04, Consultant Liaison Psychiatrist). The rigid structure, some suggested, inhibited their ability to provide a therapeutic experience: "I'm getting more and more sceptical about whether we can make the assessments that we do therapeutic" (MHP01, Locum Psychiatrist). As a result, many discussed how they would deviate from the assessment structure and aimed to "be flexible" (MHP18, Senior MHP) and "nuanced" (MHP04, Consultant Liaison Psychiatrist): "That helps a patient to feel heard. We are not just doing a clinical procedure and ticking the boxes" (MHP18, Senior MHP). They felt that straying from the assessment structure allowed for meaningful conversations.

However, MHPs felt "quite anxious about not doing full assessments" (MHP09, Mental Health Nurse), particularly after learning that a patient had taken their own life. This anxiety stemmed from concerns about the coroner's court and the need to provide evidence of completing the assessment thoroughly.

4.2. Pressure to discharge and lack of resources

MHPs reported pressure to discharge patients impacts how patients are managed. A shortage of inpatient beds meant MHPs were positioned as gatekeepers, rationing access to inpatient beds. One MHP reflected: "if you admitted everybody who said that they were going to kill themselves or that they were at risk of harming themselves - you just wouldn't be able to do that" (MHP16, Team Lead).

While some MHPs agreed that patients experiencing distress or anxiety were not appropriate patients for ED services, they acknowledged that these patients often have no alternative route due to limited resources. They stated although they plan for services in the community to follow-up with patients after discharge from the ED, these services do not always follow through: "Whether the services you've plann[ed] to put in place to keep them safe will actually work in the way you intend them to work… cause if they don't, then your whole assessment of the patients' safety is flawed" (MHP02, Senior MHP). Consequently, many MHPs expressed a lack of confidence in the reliability of follow-up care patients receive after being discharged, undermining their safety planning efforts.

4. Discussion

This paper explored MHPs' experiences of conducting psychosocial assessments with people presenting to the ED with suicidal thoughts and behaviour. Nuanced accounts revealed the limits of risk categorisation, formulaic assessment templates and organisational pressures to discharge. These factors created barriers to therapeutic engagement. In line with other research, we found that risk categorisation was inextricably influenced by a variety of factors relating to the patient, staff and organisational context (McCarthy et al., 2024).

Suicide risk was central to the psychosocial assessment, yet it was categorised quickly and objectively. MHPs categorised risk into high, medium or low, reducing nuanced experiences of suicidality to its possible end point, i.e. whether the person does or does not take their own life, rather than a reflection of suffering. This approach divests suicide of meaning, intent and agency and limit efforts to understand suicidal experiences (Wyder et al., 2021). Observational research similarly found MHPs use 'yes-no' question formats to ask about suicidal thoughts and the ability to keep safe to facilitate risk categorisation (McCabe et al., 2023).

Structured assessments were widely described as hindering open, therapeutic conversation with patients (Xanthopoulou et al. 2021; Mughal et al., 2023). While some MHPs used the structured assessment to 'cover their backs', especially after a patient suicide, many felt disheartened by the emphasis on using rigid assessments over relational care. Fear of litigation and coroner's court shaped some MHPs' reliance on rigid templates overshadowing therapeutic potential and patient-centred approaches (O'Keeffe et al., 2021).

Institutional pressures to assess and discharge within limited time were barriers for therapeutic assessments. In line with previous studies, 'tick-box' approach to risk assessment were linked to focus on aspects of risk that felt irrelevant to patients in crisis (O'Keeffe et al., 2023; Hawton et al., 2022). Many MHPs described discarding the structured assessment template to conduct a more meaningful and patient-centred assessment. This aligns with (Royal College of Psychiatrists, 2025) guidance that "good relationships make assessment easier and more accurate and might reduce risk." Such shifts reflect wider critiques of standardised assessments and a growing movement towards relational, collaborative approaches (Griffiths et al., 2025; Hawton et al., 2022).

MHPs assessed the credibility of patients' accounts against their own preconceptions of how genuinely suicidal individuals behave. They were particularly sceptical of those perceived as "trying to get psychiatric beds," while those who concealed suicidal intent more closely aligned with the image of "legitimately suicidal" person. We found that MHPs questioned patients' capacity to provide intelligible accounts (Sherman and Goguen, 2019) by presenting contrasting information (e.g. future plans) or collateral information to question their credibility and their suicidal intent. These reflections mirror observational studies showing MHPs implicitly or explicitly dismiss the patients' accounts during assessments, undermining agency and trust (Bergen et al., 2023). Some MHPs reported encouraging a positive outlook and using a strengths-based approach in the assessment while others felt this was counter-therapeutic.

Stigma played a notable role in shaping risk assessments for people with a personality disorder or who were "frequent attenders" to ED. The stigma attached to this diagnosis influenced interactions and diminished MHPs' confidence in the credibility of patients' accounts. Repeat attendances were often interpreted as chronic behavioural patterns, leading them to classify these individuals as low risk. This is despite established link between previous self-harm and increased risk of suicide (Favril et al., 2022). It is important to address stigma as it not only influenced decision-making but also compounds distress and can undermine trust in services (Trevillion et al., 2022). Previous research in community settings similarly identified stigma as a barrier to best practice care and suggested stigma may emerge due to staff burnout (Trevillion et al., 2022).

Finally, MHPs reflected on the limitations of the assessment outcome itself. Most viewed the risk assigned as temporary and only reflected risk levels at the point of assessment and shortly after discharge. This highlights the importance of timely aftercare. Yet, there was widespread concern about the provision of aftercare in community mental health services. This reflects the experiences of patients who described being given "trivial treatment plans" (e.g. leaflets, helplines) or signposted to services with no capacity (Xanthopoulou et al., 2021). The review highlights such practices stem from structural constraints and contributes to moral distress as MHPs struggle with the ethical implications of signposting patients to services they know are inaccessible (Beale, 2022; Quinlivan et al., 2023).

5. Limitations

This study was conducted in a single ED with a non-diverse sample of MHPs. Future studies can explore

positive practice in different EDs. The MHPs who participated in the interviews self-selected introducing a potential bias for MHPs who are more comfortable discussing the challenges of assessing suicide risk. Although the interviews were conducted in 2019, these practices as well as the institutional pressures MHPs reported, still persist within the UK ED mental healthcare (Uddin et al., 2024).

The study relied solely on interviews with MHPs and did not include the perspectives of patients or people with lived experience (reported elsewhere). While a lived experience researcher was included in the study, the experience of psychosocial assessments is limited to one side of the interaction. Furthermore, while MHPs included various professional roles, the analytic approach did not explore how perspectives or practices might differ between MHP types.

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