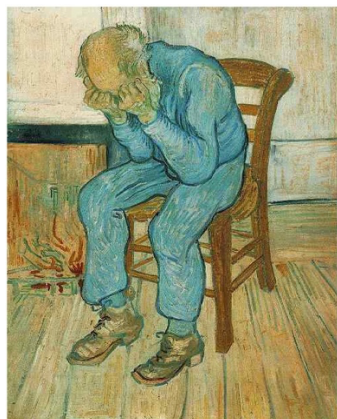University of East Anglia

# Identifying Depression and Suicidality in People with Post-Stroke Aphasia

Background
The artworks included in this poster can be interpreted as conveying depression without words. This is a challenge faced not only by these artists, but also for stroke survivors with both aphasia and depression. Multiple stroke guidelines recommend screening **all** stroke survivors for low mood; as roughly 1/3rd experience depression. Stroke has also been highlighted as a risk factor for suicidality; several mental health guidelines recommend screening those with risk factors. 1/3rd of stroke survivors have aphasia, and they are at increased risk of developing depression. However, traditional methods of screening for low mood and suicidality rely on verbal methods (e.g. interviews and questionnaires) making them often inaccessible for people with aphasia (PwA). However, no research has yet explored screening rates and methods in PwA.

Research Questions
What rates and methods of screening for low mood and suicidality do staff working in stroke report to use with PwA?
Is the Theory of Planned Behaviour (TPB) an effective model for understanding staff intent to screen for low mood in PwA?
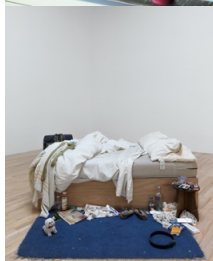

Design & Methodology
An online snowballing campaign was conducted to recruit UK stroke professionals using social media and UK-based professional bodies and special interest groups. An online survey was created to explore the rates and methods of screening PwA for mood and suicidality. To determine what factors predict screening rates, the TPB model was applied to reported likelihood to screen for low mood. A multiple regression analysis analysed how well TPB predicts respondent intention to screen for depression in aphasia.

Results
118 Stroke professionals completed the online survey. Respondents came from across GB, were from multiple professions and across the service pathway.
Most respondents reported a **100% likelihood to screen for low mood** (mode) whereas most respondents reported a **0% likelihood to screen for suicidality**. All professions reported themselves to be less likely to screen for suicidality than mood.
A mixed method for screening was very common- ¾ of respondent reported using clinical interview and ¾ reported using a standardised self-report measure. **Almost all respondents reported using supported communication adaptions**.
TPB variables accounted for 48% of variance in intention to screen for depression (R^2=.48, F (3,101) =30.60, p<.001) with normative beliefs significantly predicting likelihood to screen for depression in PwA (β= .62, p<.001).
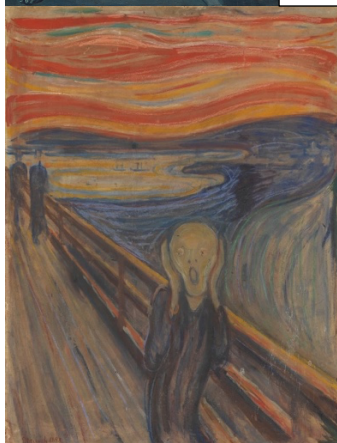
Discussion
Encouragingly, when comparing our research to similar studies in stroke samples (Lees et al; Hart & Morris) mood **screening rates were not markedly lower for PwA**. However, **screening methods are different in PwA.** Notably, **this high screening rate was not echoed for suicidality screening**, despite the severity of the risks involved. This is the first study looking at staff's reported suicidality screening rates.
These findings suggest that more support is needed to help stroke professionals detect depression and suicidality in PwA. Screening rates may be improved by communicating a clear expectation that staff should screen all stroke survivors for depression and suicidality by naming screening in job descriptions, sharing guidelines for depression and suicide screening, and auditing and publicising screening rates externally and internally.