**Appendix 1.** Direct quotes from 22 experts who provided comments specific to recovery phase or scenario. Quotes are presented in the order of the largest to smallest numbers of participants in a discipline, and within each discipline, ordered by age. Quotes were corrected in brackets for misspelling or grammar errors. For unclear descriptions or statements, the authors’ interpretation was also inserted in brackets. \*Highly experienced expert.

***Occupational therapy (n = 6)***

* 58-yo,\* US

*Ideal Scenario*

Subacute and chronic phases: “*At this moment the patients should have already fully recovered neglect*.”

*Reality Scenario*

Subacute and chronic phases: “*At this moment the patients should have already fully recovered neglect*.”

* 54-yo,\* US

*Ideal Scenario*

Earliest phase: *“I suppose, before treatment, he has a trunk control to perform treatment. My first goal would be to treat his awareness of deficits through bottom-up techniques.”*

Acute phase*: “The goal at this stage is to treat neglect with the most effective methods and to address general attentional problems.”*

Subacute phase*: “Continue previous treatment”*

Chronic phase*: “The kind of treatment will depends on the residual symptoms of spatial neglect, anosognosia, and physical condition.”*

*Reality Scenario*

Earliest phase*:* “*I just work in rehabilitation center not in stroke unit, and in* [my] *department there are only patients* [who are] *>1months post injury.”*

* 43-yo,\* Australia

*Ideal Scenario*

Earliest phase: *“I would ask the patient for his preferences and observe his capabilities and adapt trainings accordingly. If he is very motivated and capable to participate in more active training, I would offer more options as marked for the next phase. In addition I would motivate the patient - in all phases - to participate in a study to measure effectiveness of the training along with the rehabilitation from the very beginning to* [use the findings as] *recommendations for future patients.”*

Acute phase*: “I would study effects of treatments and especially their combination along with the treatment as stated above. Again, I would ask the patient for his preferences and observe his capabilities and adapt trainings accordingly.”*

Subacute phase*: “Treatment in this phase would depend on persistence of neglect. If still present, treatment will be based on a selection of the marked options, depending also on the effects observed in the previous phases.*[I would consider] *stimulation, either tDCS or TMS.”*

Chronic phase*: “Again, treatment depends on persistence of neglect. If [no symptom of spatial neglect is present], no treatment will be necessary. Otherwise, marked options apply - along with a study. All these suggestions refer to an ideal world - in reality there will hardly be the capacities to apply all those treatment options and study their effects independently as well as in their combination.”*

*Reality Scenario*

Earliest phase*: “Again I would motivate patient to participate in study as not all treatments and in particular their combination are not sufficiently established yet with respect to reliable effects. This applies to all phases.”*

* 37-yo, UK

*Ideal Scenario*

Earliest phase: *“Many of these options are not yet in treatment guidelines since their effectiveness in improving independence in ADL has not been proven. My choices take into account my preferences for treatment, comfort of the patient and not wanting to overwhelm the patient with too many interventions.”*

Acute phase*: “More of the same, but pharmacological treatment may be added to boost arousal and general attention”*

Subacute phase*: “I think I would give up on 'priming' interventions such as prism adaptation and pharmacological treatments if they hadn't proved effective in the first 3 months. I would continue with the top-down treatments so long as resources for therapists or support workers were still available.
I think the active motor interventions particularly are worth pursuing as the motor control slowly improves, it might affect attention to the affected side.”*

Chronic phase*: “Ever the optimist!”*

*Reality Scenario*

Earliest phase*: “Currently few services in UK have equipment or therapy resources for additional bottom-up treatments. The items ticked can be easily incorporated into usual physical or occupational therapy.”*

Acute phase*: “Rehabilitation is usually available in the UK during this period.”*

Subacute phase*: “By now the therapist would have to try to find family members to help the patient to practice attending to the affected side.”*

Chronic phase*: “Few people are seen by rehabilitation services at this time.”*

* 28-yo, US (Ideal scenario only)

Earliest phase*: “1) Run tests to classify spatial neglect, 2) Based on the type of spatial neglect, treatment options will differ, 3) tDCS may be more effective if provided in combination with other behavioral/ pharmacological treatments”*

* 25-yo, US (Ideal scenario only)

Earliest phase*: “In an ideal world we would have much more evidence regarding the use of these different interventions for mild moderate and severely affected patients at acute, subacute and chronic time points. The results of* [certain large-scale randomized clinical trials] *suggest that MORE is not always better in the* [earliest] *phase. Therefore caution is warranted regarding the overly aggressive treatment of neglect in* [this] *phase. Therefore I have listed only 2 low-demand activities that are multisensory that are not likely to cause harm. But the interventions checked in the following sections may be effective in* [this] *phase as well.”*

Chronic phase*: “At all phases except acute, brain stimulation could be judiciously combined with activity based therapies to enhance their efficacy.”*

***Physical Medicine and Rehabilitation (n = 5)***

* 64-yo, Italy

*Ideal Scenario*

Chronic phase*:* “*I do not typically see* [patients] *at this phase of recovery.”*

*Reality Scenario*

Chronic phase*:* “*I do not typically see* [patients] *at this phase of recovery.”*

* 52-yo, Portugal (Ideal scenario only)

Earliest phase: *“It is difficult logistically to get to patients this early.”*

Acute phase*: “This phase is the best time logistically to deliver therapies. There is no evidence or good argument against delivering these therapies in the acute phase.”*

Subacute phase*: “The strongest evidence for these interventions is from studies with patients in the subacute phase. Therefore, if the treatments* [are effective]*, perhaps they should be repeated.”*

Chronic phase*: “It is unknown if maintenance therapy is needed or helpful.”*

* 50-yo,\* US (Ideal scenario only)

Acute phase: *“Maybe brain stimulation if we know that it would actually help... so far I'd say use tDCS during learning activities.”*

* 49-yo, Portugal (Reality scenario only)

Earliest phase: *“The sequence of treatments is not very important. What is important is the number of hours of therapy during the day. Based on patient's tolerance,* [it can be] *from 3 to 8 hours a day of different treatments.”*

Subacute phase*: “It is important to address adjustment to limitations.”*

* 30-yo, Portugal (Ideal scenario only)

Earliest phase: “*not sure if prism adaptation is ok to use then”*

***Neurology (n = 4)***

* 77-yo,\* Italy (Ideal scenario only)

Earliest phase: *“Would try hemi-field or monocular patching with caution to see if it decreased right eye gaze but since patching can be ineffective and in some cases increase neglect, would only possibly try it if other treatments were ineffective. Would use either limb activation or mirror therapy - would try both and see which was more effective. Would integrate visual scanning within virtual reality scenes. Would place a* [wearable device] *with periodic alarms on left arm for attention to left arm.”*

Acute phase: *“Would continue treatments* [selected in the previous phase] *if changes are still being made. Would consider adding* [one treatment] *at a time over three months to assess the effects of prism adaptation, tDCS, and pharmacological treatment.”*

Subacute phase*: ‘“Treatment at this phase would depend on responses to previous treatments. If some of the previous treatments were ineffective, might try them again as treatments can be effective at different points in recovery.”*

Chronic phase*: “Treatment would depend on responses to previous treatment, and on the level of awareness* [of spatial neglect and related deficits]. *At this point, if awareness is emerging, the patient may continue to show* [improvement after treatment]. *If some of the previous treatments were ineffective, might try them again as treatments can be effective at different points in recovery.”*

* 77-yo,\* US

*Ideal Scenario*

Acute phase*: “Sustained attention training may be appropriate depending on the attentional level of the patient.”*

Subacute phase*: “A one-month follow-up is probably useful.”*

Chronic phase*: “Again, short follow-up trainings (two-three weeks) may prove useful, depending on the patient’s condition.”*

*Reality Scenario*

Subacute phase*: “A one-month follow-up is probably useful.”*

Chronic phase*: “Again, short follow-up trainings (two-three weeks) may prove useful, depending on the patient’s condition.”*

* 50-yo, Switzerland (Ideal scenario only)

Earliest to chronic phases: “*I'm not familiar with several of the treatment options, for example caloric/vestibular stimulation, pharmacological treatment etc.; therefore I haven’t chosen any of them*.”

* 42-yo, Belgium (Ideal scenario only)

Earliest phase: *“Considering anosognosia and awareness problems could be present, it would be better to start with passive training performed at least once a day for 30 minutes.”*

Acute phase*: “I would increase treatment* [intensity] *such as 1 hour per day of combined treatments.* [I would also add] *active training, which requires compliance.”*

Chronic phase*: “*[Treatments] *will be applied only if neglect is still present.”*

***Psychology or Neuropsychology (n = 3)***

* 58-yo,\* Norway

*Ideal Scenario*

Acute phase: *“Perhaps combine limb activation with task-specific training or with scanning tasks. Or may prime other tasks by doing limb activation first. Would love to experiment more with prism adaptation.”*

Subacute phase*: “Again, it depends on progress. If problem is resolving, there may need more maintenance.”*

Chronic phase*: “Hopefully neglect has resolved. I would consider further questions. Are there residual attention difficulties? Constructional apraxia? Other areas that need more focus now?”*

*Reality Scenario*

Chronic phase*: “*[patients] *not likely to be seen for treatment at this point”*

* 55-yo, Switzerland (Ideal scenario only)

Earliest phase: “[SEP/OKS] *or prism, depending on the oculomotor pattern of the patient.”*

Subacute phase*: “It is hard to tell. It depends on the original severity of the neglect deficit and* [whether the patient recovers]*. I'm assuming we have worked on anosognosia and reading effectively.”*

* 43-yo, Italy (Ideal scenario only)

Earliest to chronic phases: “*While there is evidence of effectiveness for many of the items you have listed for neglect, I do not have personal experience with them and what I have listed is enough for the patient to make gains that will allow return to function. I appreciate the perfect world scenario, but if I do not have personal experience with something, am I supposed to say I would use it if I've never done it personally and therefore have found it to be unnecessary? In addition, some of the terms I am not familiar with and therefore it is difficult to know if the educational component that I provide and the activities that I do with these persons in therapy would fall under some of these categories but I did not choose them because I am unfamiliar with the terminology.*"

***Nursing (n = 3)***

* 60-yo, US

*Ideal Scenario*

Acute phase: *“Would really like a new Dynavision, computer software (e.g., Ace Reader).”*

Chronic phase*: “I only say ‘None’ as there are no notes to indicate impairment level - need an update.”*

*Reality Scenario*

Chronic phase*: “Depending on residual deficits at this point.”*

* 59-yo, US (Ideal scenario only)

Earliest phase: “[Hemi-field] *patching vs. prism adaptation would depend on more specific information regarding the patients neglect profile.”*

* 38-yo, nursing, US (Ideal scenario only)

Subacute and chronic phases: “*I don't know. Not my* [patient] *population. Need to read* [evidence-based practice guidelines].”

* 30-yo, nursing, US (Reality scenario only)

Earliest phase: *“not sure if prism adaptation is ok to use then.”*

***Physical Therapy (n = 1)***

* 60-yo,\* Belgium (Ideal scenario only)

Subacute phase: “*If GVS was unsuccessful then I might recommend one or two other experimental approaches.*”

**Appendix 2.** Direct quotes from 4 experts who shared their opinions related to situations experienced in their workplace. These texts were left at the end of the survey where the instruction stated “Thank you for your participation in this survey. You are welcome to leave your comments below.” Quotes were corrected in brackets for misspelling or grammar errors. For unclear descriptions or statements, the authors’ interpretation was also inserted in brackets.

***Neurology***

* 57-yo, Brazil

“*Initially I had some problems convincing nurses … because there are no treatments specified in the national guidelines. They took this to mean that there was no suitable treatment for neglect however 'reorientation' is now routinely addressed by all staff.*”

* 50-yo, Switzerland

“*Spatial neglect has not been the priority during the nearly 14 years I have worked here but during the last two years we have done a lot of work to make it a priority. We are not there yet but we are working on it!”*

 ***Physical Medicine and Rehabilitation***

* 52-yo, Portugal

*“Ever shorter inpatient stays combined with high time demands on staff related to charting together create the need for prioritization of treatments in the inpatient rehab setting. After discharge from the inpatient facility, delivery of care is hampered by high no-show rates from challenges with transportation reducing efficacy of all interventions.”*

***Nursing***

* 38-yo, US

*“Primary focus is functional ADL outcomes and patients are discharged 7-14 days after admit. Reimbursement is linked to gains in FIM scores. We typically can't justify keeping patients longer at the supervised level, and* [we] *hope that they get follow up via outpatient. … I know there is more to do, but the testing and treatment is proprietary and costly and our facility won't pay to have the training. So, we focus mostly on ADL skills, compensatory strategies, and caregiver training to promote abilities to function at home with assist.”*