Emergency Department Resource Guide for Clinical Providers and Staff Supporting Autistic People Experiencing Suicidal Ideation and Behaviors

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Purpose of This Resource

The **purpose of this resource** is to provide helpful strategies, ideas, and supports for providers and staff working in the emergency department who might encounter autistic people in crisis.

For people interested in learning more, we provide **resources** to learn more, including **peer-reviewed evidence**.

Why should emergency room providers and staff use this resource?

Autistic people and their caregivers or care partners have shared that it is hard to get medical care when needed, and emergency care is very difficult when they are experiencing a crisis. Below are quotes that provide context for why a resource guide is needed.

> "Everything is really rushed in ERs. Anyone in crisis shouldn't be rushed, but that's especially true for people with autism, because it takes them a while to process emotional stuff, and if you're asking them how they are feeling, you can't rush them." **~ Parent of autistic child**

> "...we didn't get a referral, we didn't get access to care, we didn't get... They did give me a list. I called everyone on the list, and no one was available. They described it as a desert, and they were just like, you know, 'Gee, our hands are tied, sorry.'" **~ Parent of autistic child**

> "I would try to communicate about [child]'s needs and [the clinician] would say, "Well, everyone experiences that." There was a dismissiveness and a disbelief that it is drastically different than a neurotypical experience... Even if they are 'high functioning,' this needs to be taken into account, because they are put in a position where they are misinterpreted in negative ways, it's assumed that they don't have problems." **~ Parent of autistic child**

> "The worst part of autism is when I'm in a situation where I don't know what is going to happen. I hate not knowing what is going to happen." **~ Autistic teen**

> "She [provider] didn't really understand my thoughts. Maybe she wasn't trained in autism, maybe I wasn't expressing myself. I felt like she wasn't listening to me on purpose - needless to say, I felt frustrated…" **~ Autistic teen**

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Structuring the Environment

Main Point: The context or environment of care has a major impact on a person's ability to participate in their care. Improving the person-environment fit may increase self-regulation and capacity to engage in care when in crisis.

A poor person-environment fit can overwhelm capacity for self-regulation and increase likelihood of physiological distress, which might include fleeing, fighting, or freezing. For people in crisis, their capacity is already reduced, making the environment a critical part of ensuring physiological safety.

Ways to Improve the Physical and Sensory Environment to Reduce Overwhelm for Patients in Crisis

Auditory Stimuli

- Consider a separate waiting area for people in crisis that is quiet.
- If possible, ensure the person has a separate room and is not in the hallway or a multi-bed space.
- Consider having disposable foam ear plugs for use.
- Modify provider volume and pace of speech. Use a slow-moderate pace with a low volume.

Tactile Stimuli

- Reduce the requirement for aversive touch, e.g., is a gown really required? Does the patient have to sit on a cold metal table for an exam or can they be examined elsewhere?

Visual Stimuli

- Consider reducing visual stimuli by turning off overhead lights when the person is waiting (e.g., lights are not needed for examination).
- If the lights need to be turned on from being off, provide a verbal warning.
- If turning off lights is not possible, have disposable sunglasses for use.

Olfactory Stimuli

- Encourage a scent-free emergency department by encouraging staff and clinicians to not wear scented deodorants, lotions, perfumes, or colognes.

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Communicating Effectively

Main Point: Facilitating communication can reduce distress. Communication is bidirectional.

- **Use the acronym AUTISTIC to support communication (Haight, 2026).**

  A Alternative communication
  U Unambiguous language
  T Take their word for it
  I Indicate your intention
  S Short, specific sentences
  T Time for processing/ regulation
  I Interest-based coping
  C Closed-ended questions

- **Presume competence.** Speak with the autistic person in crisis, even if they have a care partner or communication partner with them.

- **Ensure access to augmentative and alternative forms of communication (AAC).**
  - If they have a communication device, make sure they can access it.
  - If they have a communication partner, make sure they are present.

- **Offer options to reduce communication demands.**
  - Example: *Spoken* app (free), picture communication options (e.g., PECS)

- **Offer non-speaking communication options, even if the person uses spoken language.**
  - Speaking can be exhausting and unreliable and may increase distress.
  - Offer writing, typing, texting, nodding, pointing, etc.

- **Narrow the scope**
  - Reduce the vastness of questions.
  - Be very specific about what you are asking, even to the point of using closed-ended questions. This will tell the autistic person what is relevant to you. Otherwise, they may feel they have to explain everything to you, starting from the very beginning.

- **Use visual aids / supports.**

- **Establish shared knowledge carefully.**

  - Shared words are different than shared understanding.
  - Keep in mind that two people may use the same words while assigning different meanings to them.
  - Define words as you use them (e.g., "often" and by that, I mean three times in one week, etc.).
  - Seek to understand differences in interpretation with questions like "what does that question mean to you?"

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- Clarify any differences between intended meaning and interpretation *without* treating one person's account as the correct one.

- **Avoid platitudes**. Instead, say things that are irrefutably true.

  - Example Platitude: "Don't worry, it will get better."
  - Example of something that is irrefutably true: "Things will change. No state or circumstance can stay the same forever."

- **Use concrete language.**

- **Roll with resistance.**
  - Stickiness and repetition are core diagnostic criteria of autism.
  - Don’t try to fight their neurology.
  - Respect their lived experience.
  - Redirect if you must, don’t resist.

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Reducing Distress

Main Point: Reducing distress can facilitate communication.

- **Do not rush.** Provide time for processing, regulation, building trust.
- **Assess for physical pain.**
- **Listen to, and believe their words, even if their facial expression differs.**
- **"Listen" to what actions are telling you.**
  - Behaviors that challenge *are* communication - do not assume behaviors are aggressive.
- **Validate the person's experience.**
  - Address contributors to suicidality and situational stressors, and work to reduce these.

- **Suspend assumptions.** Distress may not look like what you expect because distress in autistic individuals can present differently than in non-autistic people. It may:
  - Be more direct than you expect.
  - Be shutdown.
  - 'Look fine' but be in crisis

- **View behaviors as functional communication.** Identify the function and meet the need.

- **Co-regulate with the person in distress.**
  - Sit side by side silently -- this *is* a productive use of time.
  - Ask about their areas of interest (e.g., "what is something you really love?").

- **Provide individualized regulating options.**
  - Proprioceptive and vestibular options:
    - Yoga
    - Coloring
    - Squeeze something
    - Go upside down
    - Rocking
    - Bouncing
    - Walking in tight circle
    - Weighted item, if possible
    - Pressure (e.g., hand squeezes)
  - Vagus nerve options & breathing:
    - Legs up wall
    - Physiologic breath
    - Nose plug breath
    - Sour candy, if possible
    - Cold (ice cube), if possible

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    - Belly breath (can put hand or comfort item on stomach)
    - Finger tracing breathing

- **Remove assessment demands at the first sign of dysregulation and engage in preferred activities or regulating activities before restarting assessment.**
    - If distress continues, increase the flexibility of assessment.

- **Address the sensory environment-- sensory needs are safety needs.**
    - Reduce sensory input:
        - Sounds
        - Lights
        - Textures
        - Smells
    - Provide more intense sensory input, if requested.

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Assessing Risk

Main Point: There is currently no suicide risk assessment validated for autistic people.

Adapting existing instruments is important for improving clarity and relevance and will increase the likelihood of obtaining important information to support the individual.

- **Ask about suicide directly, following your facility's suicide screening and assessment protocol.** Autistic people are concrete.
    - **Do not use** vague or roundabout questions such as "Do you feel unsafe?", "Do you think you should be in the hospital?".

- **Provide definitions and give examples.**

- **Emphasize timeframe and probe to ensure understanding of the time period that the assessment is asking about.**

- **Offer several response options**: writing, typing, pointing to visuals, or simplified responses (e.g., Yes/No).

- **Allow time for processing.**

- **Ask follow-up questions,** regardless of screen result to understand their interpretation of the questions and to confirm your interpretation of their response:
    - "What does that mean to you?"
    - "I'm going to repeat back what I heard from you, please correct me if I made mistakes."

- **Avoid emotion questions and ask about behavioral indicators when possible.** Some autistic individuals have difficulties with emotion recognition and expression. Support emotion recognition and communication (e.g., providing a list of emotion vocabulary) when necessary.

- **Involve care partners or key support people in the assessment process.**

- **Ensure that there is a comprehensive protocol for the steps to follow in case of a positive screen that emphasizes the least restrictive environment for care.**

    - Know *who* and *when* to consult about **autism-informed care**, including further assessment and safety planning.
    - Everyone plays a role in suicide prevention; each person's role needs to be clear.
    - Clinicians should ensure that they have relationships for transitioning care to the appropriate provider and support people in connecting.

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Screening for Suicide Risk in Autistic People
Given that autistic people are **three times more likely to experience suicidal thoughts and behaviors, it is particularly important that clinicians have standardized protocols for identifying and addressing suicide risk in this group and that they are applied consistently (e.g., Vasa et al., 2025). A gold standard for screening suicide risk in autistic people should be developed and consistently used.**

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Involving Caregivers and Care Partners

Main Point: While care partners, especially caregivers of autistic youth, may be hesitant about suicide prevention practices, supporting their involvement in suicide risk assessment and management is critical to promote best outcomes.

- **Ensure autonomy of the autistic person.** The autistic person should always be the first person that is involved in care and should have autonomy over decisions made about the care process. Because some autistic individuals may prefer to have a care partner present, this should be discussed prior to assessing suicidal thoughts and behaviors.

- **Fully introduce the care process to the individual and their care partner.**
  - Ask them what concerns they have and what accommodations may be helpful for them and their loved one.
  - An example care process is provided in the Appendix.

- **Educate the care partner on suicide risk in the context of unmet mental health needs and societal mismatch and stigma/discrimination for autistic people**.
  - Example: If the person has a 504 plan at school and is experiencing bullying and educational exclusion, then recommending outpatient psychotherapy does not adequately address the unmet mental health need.

- **Refer for services and supports to address unmet mental health needs or system barriers**.

- **When conducting a suicide risk assessment, obtain perspectives from care partners.**
  - If permitted by the autistic person, ask about their interpretation of their loved one's responses.
  - Provide psychoeducation. While suicide risk in autism is real and highly prevalent, it is vulnerable to invalidation or minimization in the context of other treatment targets. Engage in conversation about the importance of prioritizing safety and teaching adaptive coping and communication skills.

- **Do not solely rely on the report of the care partner or support person.**
  - Autistic individuals, including autistic youth, should be given as much agency as non-autistic people.
  - While care partners have incredible knowledge of their loved one, they may not always have insight into suicidal thoughts of the autistic person.
  - Care partners and autistic people may also have different beliefs about what is going on.

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- **Involve care partners in safety planning and support planning for next steps after the emergency department.**
    - Prepare care partners to support implementation of the safety plan at home.
    - Co-develop an individualized plan for monitoring symptoms and indicators for when higher level care should be considered.
        - Example, a youth might be observed to have increased consumption of depressive scenes of movies on YouTube, signaling increased feelings of depression
    - Leave room for discussion about the care partner's concerns, emphasize the importance of a team-based approach to addressing suicidality, and validate worries about the fit of different care settings for autistic individuals.

- **Acknowledge the challenges associated with coordinating services across systems and accessing mental health care for autistic people.**
    - Care partners should be prepared for and educated on potential barriers and equipped to address barriers.

- **Acknowledge the challenges associated with caregiving.**
    - Family stress should be acknowledged and attended to, particularly given their importance in supporting at risk individuals and in securing needed intervention services.

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Changing Hospital Policy and Systems of Care

Main Point: Leadership has a role in shaping hospital policies that support patients. Whenever possible, consider opportunities for education and evidence-based policies that can support patient wellbeing.

Providers should be expected to uphold these policies and given the resources necessary to do so.

- ☐ **Modify clothing and gowning practices.**
  - Patients may remain in personal clothing when medically safe.
  - Sensory-friendly clothing or gown alternatives are available.
  - Blanket gown requirements for suicide risk should be eliminated or revised.
  - Rationale is documented when gowning is required against patient preference.

- ☐ **Allow personal objects and sensory supports.**
  - ED permits personal regulation items (e.g., fidgets, stuffed animals, headphones).
  - Approved item list is individualized and staff-accessible.
  - Removal of items requires specific safety justification specific to the individual, not default practice.
  - Sensory kits are available when personal items are restricted.

- ☐ **Promote policies that support physical environment and sensory safety.**
  - Option for low-stimulation spaces (reduced noise, dimmable lighting).
  - Limited unnecessary room entries and overhead announcements.
  - Visual supports are available (whiteboards, written explanations).

- ☐ **Support EHR integration with communication supports.**
  - EHR includes a dedicated field(s) for neurodiversity-related accommodations.
  - Communication preferences (written, literal, extra processing time) are documented:
    - Sensory triggers and calming strategies are visible across care teams
    - Accommodations persist across visits and departments
    - Should be identified collaboratively

- ☐ **Include staff and clinician training & accountability about autism & suicide.**
  - Topics may include: autism and suicide risk, effective communication strategies, presuming competence, and sensory-informed crisis care.
  - Training includes autistic voices and lived experience.
  - Ongoing patient feedback should inform ongoing improvement.

- ☐ **Promote policies that allow for support person inclusion.**

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- Patients may designate a support person to be present in the ED **at their discretion.**
- Support persons are allowed during psychiatric and suicide risk evaluations unless contraindicated.
- Staff are trained to distinguish support persons vs. visitors.
- Support persons are included in safety planning and discharge (with consent).

- **Strengthen discharge planning for mental health and suicide risk.**
  - Discharge planning for autistic patients should draw on multidisciplinary input (e.g., social work, behavioral health, case management).
  - EDs should maintain accessible, up-to-date information on autism-specific resources, including neurodiversity-affirming mental health providers, crisis services, and peer/family supports.
  - Discharge plans explicitly address mental health needs and the drivers of suicide (e.g., social isolation, sensory overwhelm, burnout, unmet support needs, co-occurring conditions), not solely the presenting concern.
  - Referral pathways to autism-informed follow-up and safety planning are built into standard disposition workflows rather than assembled ad hoc.
  - Plans are communicated in accessible formats (written summaries, plain language, visual supports) and shared with the patient's designated support person when consented.

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Resources and Reference Material

AASPIRE Healthcare Toolkit: https://researchautism.org/healthcaretoolkit/

Autism and Suicide Prevention Workgroup. *Resources* [webpage]. https://www.autismcrisissupport.com/resources

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Appendix - Care Process Outline

- Many autistic individuals will cope better with the demands of the ED if provided with resources which increase predictability.
- We encourage your ED to develop or tailor your own process guide to your setting and provide the guide to autistic patients presenting for care.
- It will be important to explain that there isn't one way and that emergency departments may have slightly different workflows and care processes. It is also important to explain that there may be a lot of time spent waiting before and between assessments.
- This visual outline includes written content developed by humans and visuals incorporated by CHatGPT and provides a general overview of what the process typically looks like.

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Your Care Journey in the Emergency Department (ED)

This is a general process. Your experience may vary.

1 Check in and Triage Process



Nursing staff conducts **initial assessment** of safety and presenting concern to inform the care process.

Staff may ask about any **accommodations** or specific care processes.

Initial suicide risk screening often happens at this time.

Suicide risk screening involves answering a standard set of questions about the suicidal thoughts and behaviors you have been experiencing. It is important to answer honestly during this assessment so the care team can provide you with the most appropriate support. It is also important to tell the clinician doing the assessment if a question or direction is unclear on the assessment.

2 Waiting to be seen



You may wait for some time before your initial assessments.

To help the time pass:

- Use phones, tablets, Wi-Fi
- Read or listen to music
- Ask for comfort items
- Ask staff if you need support

3 Initial Assessment: Medical Assessment and Mental Health Evaluation

The care teams can vary in size from a couple to many people, and these people may be present at different times during your visit.

Medical Assessment

Typically provided by a medical provider, like a doctor or nurse practitioner, and will likely include a physical exam.

Mental Health Evaluation

Typically conducted by a mental health provider, like a social worker or psychiatrist, and will ask more about your current symptoms and mental health history.

4 Waiting



You may wait again while the care team reviews information and plans next steps.

Let staff know if you are feeling worse, need support, or have any questions while you wait.

5 Discuss Possible Next Steps with a Provider

The care team will recommend next best steps for your care.

This might include more assessment.

Discharge Home

You will be discharged home, with outpatient follow-up services scheduled or recommended.

More Assessment

You may need additional tests, evaluations, or time for the care team to learn more.

Admission to a Hospital

You may be admitted to a hospital for more support. You may have to wait in the ED or another unit until an inpatient care placement is secured.

You are not alone.
Our team is here to support you.

Ask questions | Speak up about needs | You matter | We're here to help

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