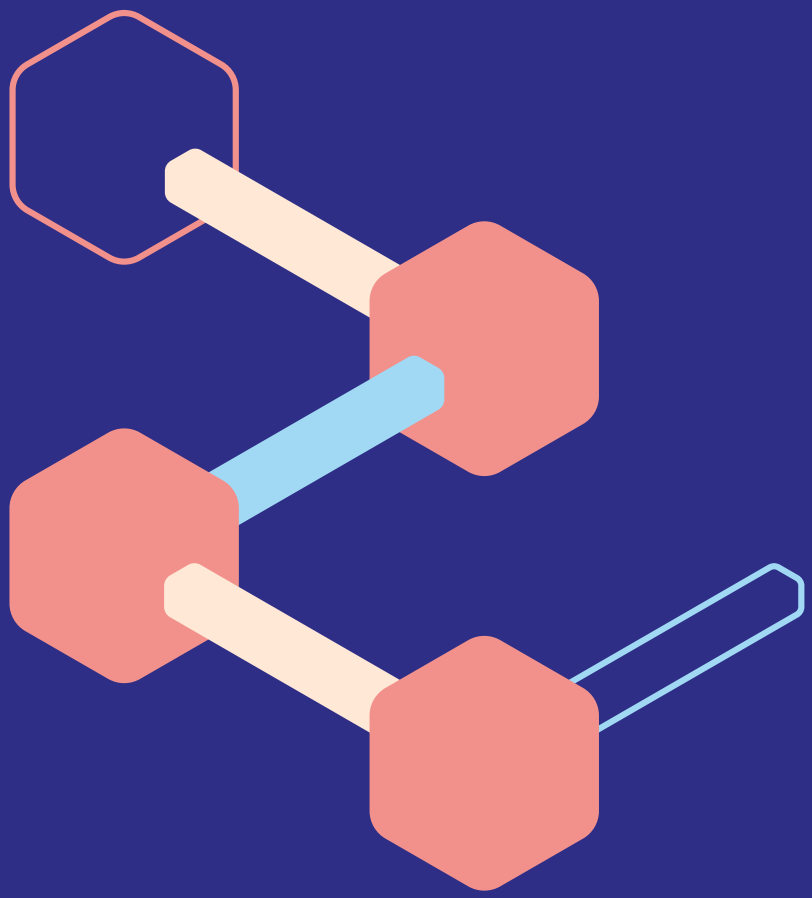

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Preface

Funding

The Suicide Prevention for Autism Neuroaffirming Toolkit (span.toolkit) project was funded by a Suicide Prevention Australia Post-Doctoral Research Fellowship awarded to Dr Claire Brown, with additional financial support from La Trobe University and the Olga Tennison Autism Research Centre (OTARC). The span.toolkit was developed in collaboration with Amaze, Aspect, Barwon Health, Different Journeys, Monash Health, Monash University, Roses in the Ocean, and Yellow Ladybugs, who provided in-kind support. Sections of the toolkit were developed with funding from a Suicide Prevention Australia Fellowship awarded to Associate Professor Darren Hedley.

Disclosures

- D.H. is a past Suicide Prevention Australia National Suicide Prevention Research Fellow.
- J.N.T. is supported by a National Health and Medical Research Council (NHMRC) Investigator Grant (GNT2009771).
- The Autism Adapted Safety Plan (AASP) and associated resources included in this toolkit were funded by the National Institute for Health and Care Research (NIHR) Public Health Research programme [award number NIHR129196] at the Universities of Newcastle and Nottingham, UK.

The authors declare no actual or potential conflict of interest.

Community Involvement

We extend our sincere appreciation to the autistic people, healthcare professionals, health services, autism organisations, and lived experience organisations who contributed their expertise to this project. span.toolkit was co-developed with autistic adults at every stage of planning, research, design, and implementation. These insights shaped the content, language, tools, and priorities of the span.toolkit, ensuring that it reflects the real-world needs and lived experience of autistic people.

We acknowledge and remember all persons lost to us because of suicide as well as the people left behind. We acknowledge the enduring suffering suicide brings, and the complex emotions and experiences of all people who have

contemplated suicide, and those with lived and living experience who provide hope, resilience, and support to those at risk.

Acknowledgement of Country

We acknowledge the Traditional Custodians of Country throughout Australia and recognise their ongoing connections to land, sea, and community. The Olga Tennison Autism Research Centre at La Trobe University is located on the lands of the Wurundjeri People of the Kulin Nation. We pay our respects to Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples.

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Background

Autism Spectrum Disorder (ASD; henceforth autism, autistic person; Bury et al., 2023; Schuck et al., 2025) is a neurodevelopmental condition characterised by differences in social communication; focused or intense interests; preference for routine and predictability; and a range of sensorimotor differences, including hyper- and hypo-sensitivities. Autism is currently diagnosed in approximately 1-in-100 individuals worldwide, at a rate of between 2-3 males for every 1 female (i.e., sex assigned at birth). There is increasing recognition, however, that these estimates may substantially under-recognise individuals assigned female at birth who are more likely to be identified later in life.

Autistic people experience disproportionate suicide-related burden, with consistently higher rates of suicidal thoughts, behaviour, and death by suicide compared to the general population (Newell et al., 2023). Recent global estimates indicate that autistic people have a three- to five-fold increased risk of death by suicide, with the highest mortality risk observed among autistic adults without a co-occurring intellectual disability (Santomauro et al., 2024). This elevated risk is present across regions and age groups and contributes meaningfully to years of life lost attributable to suicide worldwide (Schwartzman et al., 2025a).

Patterns of suicide risk among autistic people also differ from those observed in the general population (Schwartzman et al., 2025b). Autistic individuals assigned female at birth experience particularly elevated risk, with mortality rates exceeding those of non-autistic females and, in some cohorts, comparable or higher rates than autistic individuals assigned male at birth (Santomauro et al., 2024). Trans, gender-diverse, and LGBTIQ+ individuals are recognised as among the most at risk in society, and here too, when autistic people share these identities, suicide risk is further compounded (Polidori et al., 2024). These patterns are thought to reflect the cumulative impact of marginalisation, discrimination, delayed or missed autism diagnosis, misdiagnosis (e.g., personality or mood disorders), and prolonged exposure to inappropriate or unmet mental health care (Moseley et al., 2026a).

A review of recent literature examining suicide in autism highlights a convergence of chronic and acute risk factors that disproportionately impact autistic adults. These include high rates of co-occurring anxiety and depression, exposure to trauma and victimisation, experiences of autistic burnout, and persistent social stressors such as loneliness, unemployment or underemployment, and discrimination (Brown et al., 2024). Importantly, autistic

adults frequently report negative or invalidating experiences within healthcare systems, including feeling misunderstood, dismissed, or harmed by prior interventions, which can reduce help-seeking and limit opportunities for early identification of suicide risk (Wilson et al., 2025).

Suicidal thoughts are common among autistic adults accessing mental health services, often emerging in the context of cumulative stress, unmet support needs, and barriers to timely, affirming care (Moseley et al., 2025). Despite this, suicide prevention practices in Australia are highly variable, with no nationally mandated approach to suicide risk assessment or safety planning. Where assessments are undertaken, they are often conducted in isolation, rely on standardised tools that are not adapted for autistic social communication and information-processing differences, and may fail to capture clinically relevant information about distress, risk, and support needs (Hoare et al., 2026; Moseley et al., 2026b).

Standard suicide risk assessments frequently rely on abstract language, rapid questioning, or implicit assumptions about emotional insight and verbal disclosure. For autistic adults, these features can reduce clarity, increase cognitive load, and limit the accuracy or interpretability of responses (Hedley et al., 2023; Hedley et al., 2025). Safety planning is similarly not undertaken consistently, collaboratively, or in ways that autistic people describe as meaningful or usable in practice (Goodwin et al., 2025; Rodgers et al., 2024). As a result, critical information about suicide risk, protective factors, and preferred supports may be misunderstood, overlooked, or missed entirely.

Together, this evidence highlights the need for autism-adapted approaches to suicide risk identification, assessment, and management that are both clinically robust and grounded in autistic lived experience. The span.toolkit responds to this need by providing clinical tools developed with and for autistic adults, and practical guidance designed to support healthcare professionals to identify suicide risk accurately, engage autistic adults safely, and respond in ways that align with contemporary suicide prevention frameworks, national policy directions, and real-world practice environments.

About

The span.toolkit is a digital platform designed healthcare professionals. It provides a range of autism-adapted tools to assist in the identification, assessment, and management of suicidal thoughts and behaviour in autistic adults without intellectual disability. These are:

1. **Suicidal Ideation Attributes Scale - Modified (SIDAS-M)**
2. **Suicide Assessment Kit - Modified Interview (SAK-MI)**
3. **Autism Adapted Safety Plan (AASP)**

These tools were developed with and for autistic adults, and include modifications aimed at improving their accessibility and sensitivity for identifying suicidal thoughts and behaviour in autistic adults. These include the use of concrete and direct language, exemplars and definitions of key terms, visual response scales in additional to numerical ratings, and recommended follow-up actions for clinicians. In addition, the span.toolkit provides a range of video demonstrations and downloadable resources to support healthcare professionals administer these tools safely.

The span.toolkit also provides a range of lived experience-led education and training resources that are designed to improve healthcare professionals' understanding of common autistic experiences, barriers to accessing effective mental health support, and highlight risk and protective factors that are demonstrated to modify suicide risk among autistic adults.

Importantly, the span.toolkit is not intended to replace formal training, professional judgement, or national suicide prevention guidelines. Instead, it is designed to complement existing practice by offering autism-adapted clinical tools, practical engagement strategies, and recommendations for supporting autistic adults who are diagnosed or suspected to be autistic.

All actions taken in managing suicide risk, including those informed by the span.toolkit, should be determined by, or undertaken in consultation with, a qualified healthcare professional and conducted in accordance with relevant government guidelines, professional standards, and organisational policies.

Autism-Adapted Model of Care

What is an Autism-Adapted Model of Care?

The **span.toolkit** is organised around an autism-adapted model of care that addresses two interrelated needs:

- Suicide risk identification and management protocols developed with and for autistic adults.
- Neuroaffirming care principles that reflect autistic lived experience and best-practice approaches.

Within this model, autism-adapted clinical tools guide what healthcare professionals can do to identify and respond to suicidal thoughts and behaviour in autistic adults. Neuroaffirming practice principles guide how these actions are carried out in practice, including how questions are asked, how responses are interpreted, and how ongoing support is negotiated to promote trust, safety, and engagement.

While no standardised measure can reliably predict or prevent suicide in any individual, autism-adapted tools provide structured and targeted ways to identify suicidal thoughts, behaviours, and relevant risk and protective factors that may be missed when standard approaches are used without autism informed adaptations. This model also recognises that disclosure of suicide-related distress is shaped by relational and contextual factors. Emphasising collaboration, trust, and safety may support more accurate understanding of an autistic person's experiences and, in turn, more informed clinical formulation and decision-making.

Why is it needed?

Autistic adults experience disproportionately high rates of suicidal thoughts, suicidal behaviour, and suicide death compared to the general population. However, suicide risk assessment and management practices are often not adapted to autistic communication styles, information processing differences, sensory needs, or prior experiences within healthcare systems. These misalignments can limit disclosure and reduce the accuracy of clinical assessment.

In Australia, there are currently no national requirements for suicide risk assessment. When assessments are undertaken, they are too often conducted in isolation and without adequate consideration of a person's broader context. Similarly, safety planning is not always undertaken routinely, collaboratively, with sufficient depth (e.g., may be considered a "box ticking exercise"), or in ways that autistic people recognise as meaningful or usable. As a result, important information about distress, risk, and support needs may be misinterpreted, minimised, or overlooked.

An autism-adapted model of care is therefore needed to support healthcare professionals to gather accurate, clinically relevant information and to respond to suicide risk in ways that are feasible, appropriate, and consistent with the experiences of autistic adults.

Who can use it?

The span.toolkit is intended for healthcare professionals working with diagnosed or suspected autistic adults across a range of healthcare and community settings. It does not require specialist autism services, changes to professional roles, or additional accreditation. This model is designed to be feasible within varied clinical contexts and service constraints, and to support healthcare professionals with differing levels of experience working with autistic people.

Is it compliant with existing frameworks?

Yes. All information presented in the span.toolkit is consistent with best-practice suicide prevention approaches that emphasise clinical formulation, proportional response, and professional judgement rather than prediction or categorical risk stratification.

The model is consistent with the National Suicide Prevention Strategy 2025–2035 and is designed to complement existing organisational policies, professional guidelines, and legal responsibilities related to suicide risk assessment, triage decisions, and documentation. Importantly, the tools presented in the span.toolkit may inform clinical decision making, but they do not replace professional responsibility or organisational governance and processes

How is this model intended to be used in practice?

This model is intended to be integrated into existing clinical practice, not applied as a separate or prescriptive pathway.

Autism-adapted tools support specific points of assessment, formulation, and response, while neuroaffirming relational and contextual adjustments support engagement, trust, and accurate interpretation of information over time. These elements are used flexibly and depending on the clinical context and the needs of the individual.

Within the model (Figure 1), the Suicidal Ideation Attributes Scale - Modified (SIDAS-M) serves as the first point at which the individual is asked about the presence of any suicidal thoughts and behaviour. SIDAS-M can be administered via direct interview or self-report, e.g., via a downloadable or online, self-scoring form. Results are then reviewed by the clinician. Any past or recently reported suicidal thoughts or behaviour should be followed up by clinician inquiry. The clinician can then make a decision to monitor, or to administer the Suicide Assessment Kit-Modified Interview (SAK-MI) clinical interview to obtain further information to inform triage decisions. In addition to following standard site or legislative procedures, it is recommended that all autistic people be monitored for any suicidal distress, thoughts or behaviour due to being a high risk, priority population for suicide. While it is recommended that all autistic people who present with suicidal thoughts or behaviour complete an Autism Adapted Safety Plan (AASP), at clinician discretion and if agreed to by the autistic individual, it may also be useful to complete an AASP to manage other forms of distress.

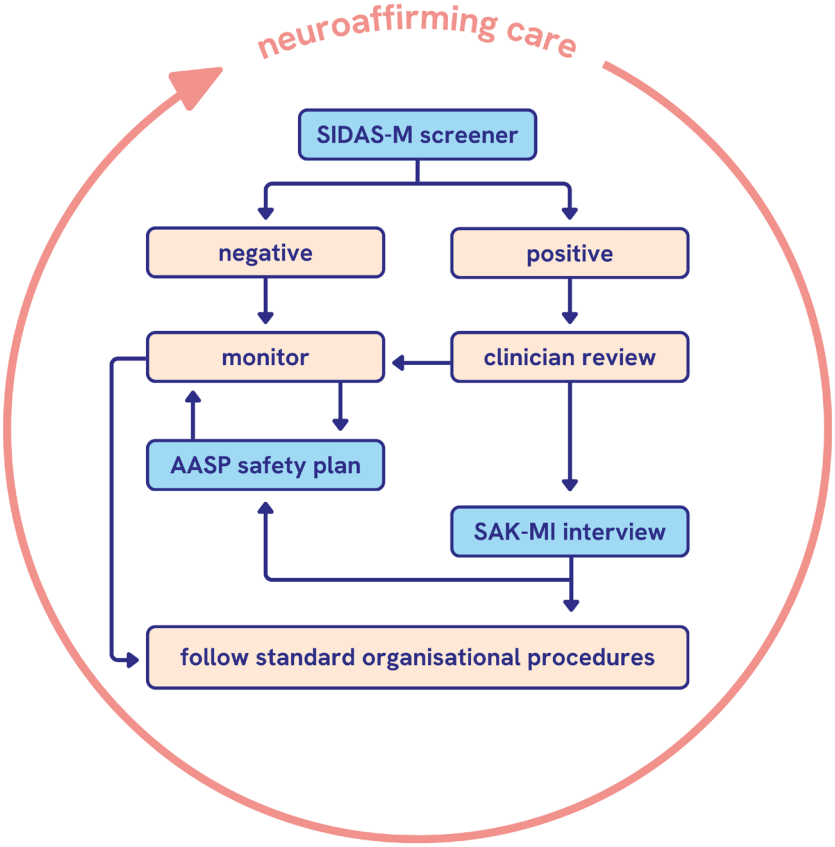

Figure 1. span.toolkit Autism-Adapted Model of Care

Detailed information about the instruments included in this manual is provided in the following sections:

4. **Suicidal Ideation Attributes Scale - Modified (SIDAS-M)**
5. **Suicide Assessment Kit-Modified Interview (SAK-MI)**
6. **Autism Adapted Safety Plan (AASP**

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1 Suicidal Ideation Attributes Scale - Modified (SIDAS-M)

Darren Hedley, Philip J. Batterham, Simon M. Bury, Angela Clapperton, Kathleen Denney, Cheryl Dissanayake, Phoenix Fox, Thomas W. Frazier, Emma Gallagher, Susan M. Hayward, Jo Robinson, Ensu Sahin, Julian N. Trollor, Mirko Uljarević, & Mark A. Stokes (2023)

About the SIDAS-M

The Suicidal Ideation Attributes Scale - Modified (SIDAS-M; Hedley et al., 2023) is a screening tool designed to identify and assess the severity of suicidal thoughts in autistic adults without intellectual disability. The SIDAS-M consists of five items, each targeting a different attribute of suicidal thoughts: Frequency, Controllability, Closeness to attempt, Distress, and Interference with daily activities.

The original SIDAS (van Spijker et al., 2014) was created for use in the general population. However, because autistic people may interpret and respond to questions differently, it was adapted through a collaborative process with autistic adults, researchers, and suicide prevention experts. Modifications in the SIDAS-M include the use of concrete language to avoid ambiguity, the addition of visual analogue scales, and response exemplars to guide interpretation. Findings from the validation study (Hedley et al., 2023) indicate that the SIDAS-M is a reliable and effective tool for detecting suicidal ideation in autistic adults, providing clinicians with a culturally appropriate and accessible way to initiate structured conversations about suicide.

Aims of the SIDAS-M

- To identify the presence of suicidal thoughts in autistic adults without intellectual disability
- To assess the severity and impact of suicidal thoughts on daily functioning

Intended age range

- Adult (18+ years)
- Clinicians may need to consider the developmental age of the respondent prior to administering the instrument. For adults with a developmental age <18 years, caution is recommended, and clinical judgement should be used to determine whether the questions are appropriate for the individual or not

When to complete the SIDAS-M

The SIDAS-M can be used as part of routine screening in mental health settings, as an initial step prior to more detailed assessment, or when there is concern about possible suicidal ideation.

The SIDAS-M takes around five minutes to complete. It can be administered as a self-report measure or with support by a qualified healthcare professional, depending on the individual's communication preferences and needs.

Please note: The role-play activity shown in the span.toolkit provides an alternative administration of SIDAS-M as a clinical interview. SIDAS-M has not yet been validated as an interview, so apply your clinical judgement when selecting an interview format in place of self-report.

The SIDAS-M can be administered in two formats:

- **Paper-based assessment**: The SIDAS-M can be downloaded and printed for use as a paper-based assessment. When using this format, the administering professional will need to score the SIDAS-M manually using the scoring instructions below.
- **Online form**: The SIDAS-M can also be completed using the online form, which is automatically scored. Once completed, the form will generate a PDF copy that can be printed or saved locally on your device. Information entered into the online form is not saved by the span.toolkit website and is not accessible to other users. All information is cleared once you leave the website or close the browser window.

Instructions for using the SIDAS-M

Before commencing

- Explain the purpose of the assessment.
- Emphasise that the questions are intended to support understanding and safety.
- Provide the visual analogue response scales and explain how they are used. These are optional and not required to complete the SIDAS-M. Always ask the individual about their preferences.
- Allow additional processing time as needed.
- Support the individual to complete the SIDAS-M as required.

How to complete the SIDAS-M

Item 1: Presence of suicidal thoughts

Item 1 assesses whether the respondent has thought about deliberately killing themselves in the past four weeks. If the person selects “Never”, a score of 0 is recorded and no further SIDAS-M items are completed.

Item 2: Controllability of suicidal thoughts

Item 2 assesses how pervasive suicidal thoughts are by asking how difficult it has been for the respondent to stop thinking about deliberately killing themselves. Scores range from 0 “Easy” to 10 “Hard”.

Item 3: Closeness to suicide attempt

Item 3 assesses how close the person has come to trying to deliberately kill themselves in the past four weeks. Scores for item 3 range from 0 “Not close at all” to 10 “Tried to kill myself”.

Item 4: Distress associated with suicidal thoughts

Item 4 assesses how distressed or unhappy the respondent has felt as a result of suicidal thoughts. Scores range from 0 “Not at all” to 10 “All the time”

Item 5: Interference with daily functioning

Item 5 assesses the extent to which suicidal thoughts have made it harder for the respondent to carry out their usual activities (e.g., work, study, daily tasks, hobbies). Scores range from 0 “Not at all” to 10 “All the time”.

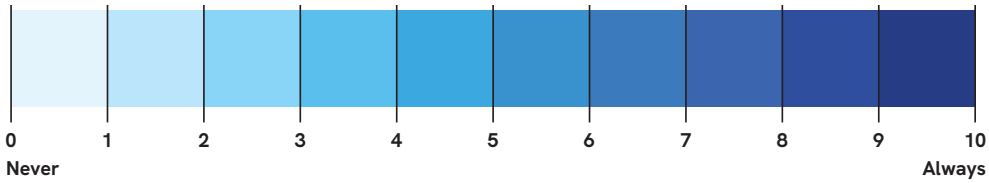
Suicidal Ideation Attributes Scale, Modified (SIDAS-M)

1. Think about the last 4 weeks. Did you think about *deliberately* killing yourself?

- Choose a **HIGH** number if you thought about killing yourself a lot
- Choose a **LOW** number if you did not think about killing yourself much
- If you ***did not think about killing yourself*** in the last 4 weeks: choose 0

Deliberately: on purpose, planned

Thinking about hurting yourself is not the same as thinking about killing yourself if you did not want to die



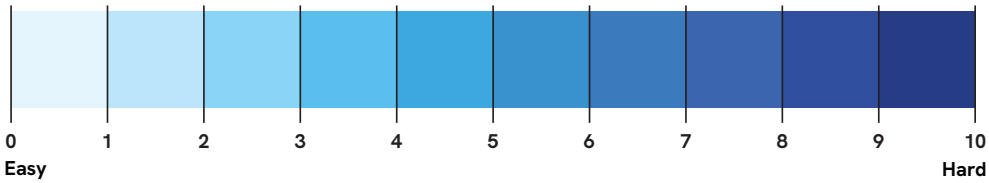
*Score = None of the time; skip all remaining items and score a total of zero

2. Think about the last 4 weeks. How *difficult* was it for you to stop thinking about deliberately killing yourself?

- Choose a **HIGH** number if it was **hard** to stop thinking about killing yourself
- Choose a **LOW** number if it was **easy** to stop thinking about killing yourself

If something is **difficult or hard** it might seem like it is impossible to do

If something is **easy** it does not take much effort to do it

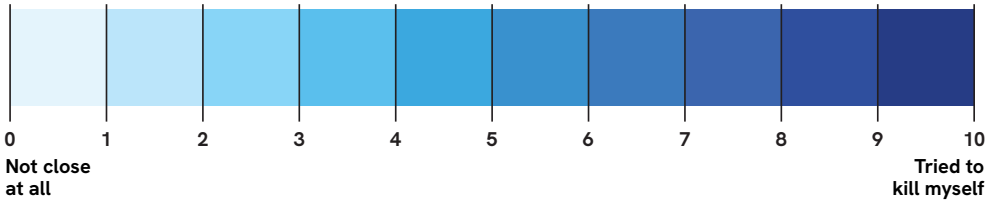


3. Think about the last 4 weeks. How close did you come to trying to deliberately kill yourself?

- Choose a **HIGH** number if you hurt yourself on purpose in the last 4 weeks and you wanted to die by the injury
- If you ***purposely tried to kill yourself*** in the last 4 weeks, choose 10

If you hurt yourself in the last 4 weeks, think about whether you wanted to die

Hurting yourself on purpose or by accident is ***not the same*** as trying to kill yourself **if you did not want to die**

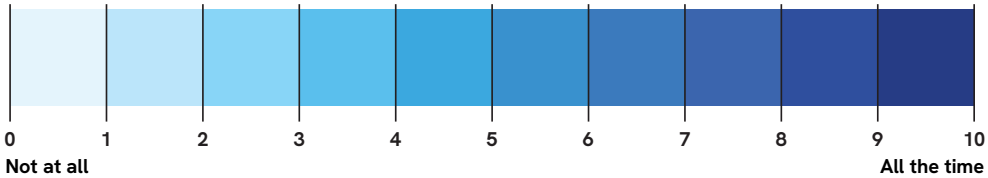


4. Think about the last 4 weeks. How often did you feel distressed or very unhappy by *thoughts of killing yourself?*

- Choose a **HIGH** number if you ***have*** felt very unhappy by thoughts about killing yourself
- Choose a **LOW** number if you ***have not*** felt very unhappy by thoughts about killing yourself

Distressed: feeling very upset

Thought: an idea, an image, a sound, or a feeling that seems to be "inside" your head

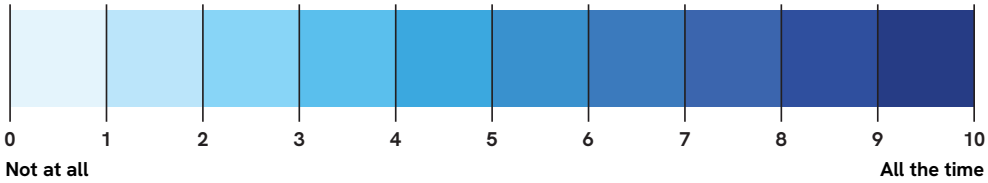


Over the last 4 weeks, what are the things you normally do? They might include:

- going to work
- study
- visiting friends or family
- going shopping
- doing things in your home
- doing a hobby
- doing something else

5. Think about the last 4 weeks. Have the thoughts about killing yourself made it harder for you to do the things you normally do?

- Choose a **HIGH** number if thoughts about killing yourself ***made it a lot harder*** to do the things you normally do
- Choose a **LOW** number if thoughts about killing yourself ***did not*** make it harder to do the things you normally do.



Note: Respondents who respond "0 – Never" to the first item skip all remaining items and score a total of zero.

Scoring: Total SIDAS scores are calculated as the sum of the five items. Total scores range from 0 to 50.Scoring and Interpretation

Scoring and Interpretation

How to score the SIDAS-M

SIDAS-M scores are calculated by summing all five items, resulting in a total score ranging from 0 to 50. No reverse scoring is required.

Higher total scores reflect greater severity of suicidal ideation and may indicate the need for more urgent or comprehensive assessment (e.g., administration of the SAK-MI).

- Score = 0: monitor over time.
- Score ≥ 1: undertake follow-up actions in accordance with professional judgement and organisational protocols.

The SIDAS-M is not designed to stratify people into "low," "moderate," or "high" risk categories and should not be relied on as a predictor of suicide attempts. The presence of any suicidal ideation (a score ≥ 1) should always be interpreted alongside clinical judgement and embedded within site-specific procedures and supports. This approach is consistent with National Suicide Prevention Strategy 2025-2035 recommendations against risk-stratification (National Suicide Prevention Office, 2025) and maximises sensitivity of the SIDAS-M for identifying the presence of suicide ideation which may be missed without explicit discussion.

CAUTION: It is the position of the authors that any identified or reported history of suicidal thoughts and behaviour immediately places the individual at potential risk of a suicide attempt. Similarly, failure to report or identify a history of suicidal thoughts and behaviour does not mean the individual is not capable of a future suicide attempt. Developing a neuroaffirming, psychologically safe environment that prioritises trust and collaborative care is essential to support open disclosure of sensitive topics such as suicidal thoughts and behaviour.

Psychometric properties

The SIDAS-M was validated in a sample of 102 autistic adults without intellectual disability (58% women, 34% men, 8% non-binary; Mage = 41.75, SD = 12.89). Participants completed the SIDAS-M alongside established suicide and mental health measures at baseline, followed by a structured interview approximately 111 days later.

Exploratory structural equation modelling supported a single-factor solution, indicating that all five items measure the same underlying construct of suicidal ideation severity. The model showed excellent fit (CFI = 0.961, TLI = 0.921, SRMR

= 0.027), with item loadings ranging from 0.74 to 0.91. Internal consistency was also excellent (McDonald's ω = .93, 95% CI .90-.95), showing that the items were highly consistent with one another.

The SIDAS-M demonstrated strong convergent validity, with scores correlating with existing suicide-specific and mental health measures, including the Suicide Behaviors Questionnaire - Revised (r_s = .698, p< .001), Columbia-Suicide Severity Rating Scale (severity r_s = .442, intensity p = .464, both p<.002), Patient Health Questionnaire - 9 (r_s = .505, p<.002), and Depression, Anxiety and Stress Scales - 21 (r_s = .325-.419, all p<.002). Divergent validity was supported by non-significant correlations with the Covid Impact Scale (r_s = -.007 to .105), indicating SIDAS-M is specific to suicidal thoughts rather than general distress.

Higher SIDAS-M scores at baseline significantly predicted suicidal behaviour at follow-up, even after controlling for age, gender, and relationship status (β = 0.462, p<.001). ROC curve analysis indicated strong discriminatory power (AUC = 0.866, 95% CI .767-.966, p<.001), demonstrating that the SIDAS-M is effective in distinguishing between autistic individuals with and without later suicidal behaviour.

Further reading

Hedley, D., Batterham, P. J., Bury, S. M., Clapperton, A., Denney, K., Dissanayake, C., ... & Stokes, M. A. (2023). The Suicidal Ideation Attributes Scale-Modified (SIDAS-M): Development and preliminary validation of a new scale for the measurement of suicidal ideation in autistic adults. Autism, 27(4), 1115-1131. https://doi.org/10.1177/13623613221131234

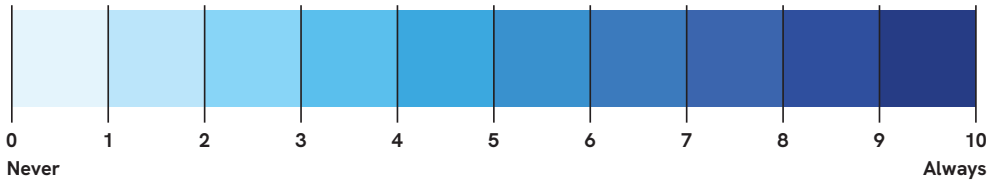
van Spijker B. A. J., Batterham P. J., Calear A. L., Farrer L., Christensen H., Reynolds J., Kerkhof A. J. (2014). TheSuicidal Ideation Attributes Scale (SIDAS): Community-based validation study of a new scale for the measurement of suicidal ideation. Suicide and Life-Threatening Behavior, 44(4), 408-419. https://doi.org/10.1111/sltb.12084

SIDAS-M Visual Response Scales

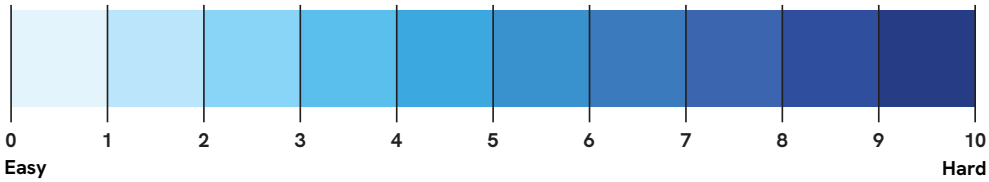
Administration notes:

Visual response scales may be provided to respondents prior to administering the SIDAS-M to support comprehension and response accuracy. Use of these scales is optional and not required to complete the SIDAS-M. Administering healthcare professionals should ask about individual preferences and use visual supports where they are helpful.

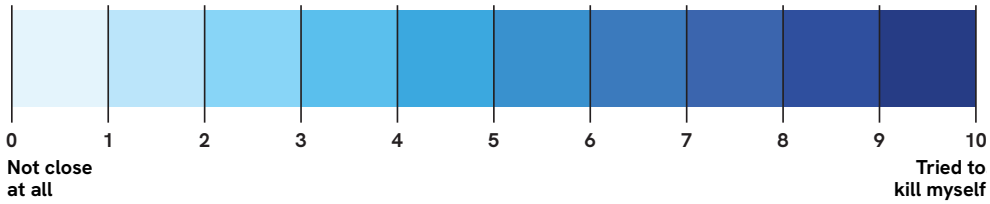
Scale 1 applies to SIDAS-M question 1



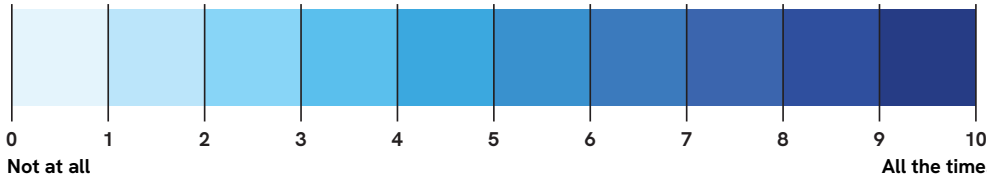
Scale 2 applies to SIDAS-M question 2



Scale 3 applies to SIDAS-M question 3



Scale 4 applies to SIDAS-M questions 4 and 5



2 Suicide Assessment Kit - Modified Interview (SAK-MI)

Darren Hedley, Zachary J. Williams, Mark Deady, Philip J. Batterham, Simon M. Bury, Claire M. Brown, Jo Robinson, Julian N. Trollor, Mirko Uljarević, & Mark A. Stokes (2025)

About the SAK-MI

The Suicide Assessment Kit - Modified Interview (SAK-MI) is a structured clinical interview designed to assess suicidal thoughts and behaviour in autistic adults without intellectual disability. The SAK-MI comprises 11 primary items, with follow-up questions used to collect additional information based on the individual's responses. The interview assesses: negative affect, current stressors, suicidal ideation and strength of ideation over time, lifetime and current suicidal behaviour, details of any suicide plans or preparations, and protective factors.

The SAK-MI builds on the original Suicide Assessment Kit Suicide Risk Screener (SAK-SRS; Deady et al., 2015), which was developed for use in clinical populations at elevated risk of suicide. Because standard suicide assessment tools may be difficult for autistic people to interpret or engage with, the SAK-MI was modified through a collaborative co-design process involving autistic adults, clinicians, suicide prevention researchers, and people with lived experience of suicide. These include the use of concrete and unambiguous language, response exemplars and definitions for key concepts, and visual analogue response scales to improve accessibility and clinical utility while retaining alignment with best-practice approaches for structured suicide assessment.

Aims of the SAK-MI

6. To identify suicidal thoughts, behaviour, and the presence of suicide plans in autistic adults without intellectual disability.

7. To provide clinicians with suggested clinical actions (triage) based on the individual's responses.

Intended age range

- Adult (18+ years)

- Clinicians may need to consider the developmental age of the respondent prior to administering the instrument. For adults with a developmental age <18 years, caution is recommended, and clinical judgement should be used to determine whether the questions are appropriate for the individual or not

When to complete the SAK-MI

Suicide risk should be assessed whenever there is some concern that the person is experiencing suicidal thought and behaviour, especially if there is any concern for a suicide attempt. The SAK-MI can also be administered at follow-up sessions to monitor any change in clinical symptoms.

The SAK-MI can be administered in two formats:

- **Paper-based assessment**: The SAK-MI can be downloaded and printed for use as a paper-based assessment. When using this format, the administering professional will need to score the SAK-MI manually using the scoring instructions below.
- **Online form**: The SAK-MI can also be completed using the online form, which is automatically scored. Once completed, the form will generate a PDF copy that can be printed or saved locally on your device. Information entered into the online form is not saved by the span.toolkit website and is not accessible to other users. All information is cleared once you leave the website or close the browser window.

Instructions for using the SAK-MI

Before commencing

- Explain the purpose of the assessment.
- Emphasise that the questions are intended to support understanding and safety.
- Provide the visual analogue response scales and explain how they are used. These are optional and not required to complete the SAK-MI. Always ask the individual about their preferences.
- Allow additional processing time as needed.

The interview should be conducted using concrete, unambiguous language, with response exemplars and definitions used where helpful. Professionals should check understanding throughout and adapt pacing as required. While it is developed to be completed in one sitting, it may be helpful to offer respondents breaks, or to pause or stop the assessment, particularly if they become agitated or distressed.

How to complete the SAK-MI

Items 1-4: Negative affect

Items 1-4 assess negative affect over the past four weeks. These items are designed to capture persistent emotional distress that may be associated with suicide risk, but they are not suicide specific. Each item is rated using a 5-point visual analogue scale. Questions 1, 3, and 4 ranging from 0 (“None of the time”) to 4 (“All of the time”). Question 2 is reverse scored from 4 (“None of

the time") to 0 ("All of the time"). Ensure the respondent can see the scale and understands how to use it before commencing. Items should be read as written. Definitions may be provided to support understanding, particularly for abstract emotional terms. Responses should reflect the person's experience over the past four weeks, not their current state alone.

Item 5: Lifetime suicide attempt history

Item 5 is a yes/no question assessing whether the person has ever attempted to kill themselves at any point in their life. This item is categorical and is not scored using the visual analogue scale. If the person answers "No", proceed to Item 6. If the person answers "Yes", complete Items 5a and 5b.

Note that this item must be administered as written. While the language may appear to be very direct, Autistic adults requested that direct, unambiguous language be used wherever possible, and specifically requested this language during tool development.

Item 5a: Number of suicide attempts

This item assesses the number of lifetime suicide attempts. Select one response option only. This item is categorical and is not scored using the visual analogue scale.

Item 5b: Recency of most recent suicide attempt

This item assesses how long ago the most recent suicide attempt occurred. Select one response option only. If the person is unsure of timing or unwilling to disclose details, select "I don't remember". This response is clinically meaningful and should not be treated as missing data.

Item 6: Ongoing impact of past events

This is a yes/no item assessing whether past events are experienced as distressing or impactful in the present. The purpose is to determine whether historical stressors continue to contribute to current emotional distress.

Item 6a: Areas of life contributing to current distress

The purpose of this item is to identify current sources of stress, not the severity of distress. This item allows multiple selections, as several life domains may be contributing simultaneously. Options may be read aloud, or the person may review the list visually. Definitions may be provided to support understanding. If "Other" is selected, record the person's wording verbatim.

Item 7: Presence of suicidal ideation over past four weeks

Item 7 assesses whether the person has experienced suicidal thoughts in the past four weeks. This is a yes/no question and is not scored using a visual analogue scale. If the person answers “Yes”, complete Items 7a–7d to gather additional information about frequency, intensity, and duration of suicidal ideation. If the person answers “No”, indicated by 7e (“If 7 = No”), do not complete items 7a–7d and proceed directly to Item 10.

Items 7a–7d: Characteristics of suicidal ideation

These items assess the frequency, strength, persistence, and recency of suicidal thoughts. Items are completed only if the response to Item 7 is “Yes”. Follow the response format specified for each sub-item, using visual analogue scales where indicated. Ensure the person understands each scale before responding. If the person is unsure or unable to quantify their experience, record the response that best reflects their understanding.

Item 7e: No reported suicidal thoughts in last 4 weeks

Do not administer items 8–9, proceed directly to item 10 (support networks)..

Item 8: Presence of suicide plans

This item assesses whether the person has a current plan for how they would attempt to kill themselves. It is a yes/no question and is not scored using a visual analogue scale. If the person answers “No”, proceed to Item 9. If the person answers “Yes”, complete Items 8a–8c. Intent to proceed with suicide plans should not be based on the presence of a plan alone. If the person is unwilling to disclose details of their suicide plan, this should be recorded explicitly.

Items 8a(i) - 8c: Details of current suicide plan

These items involve both open-ended questions and yes/no responses to understand the person’s plan in their own words, as well as their access to means to carry out this plan, the location for their plan, and how advanced their preparations are. The purpose of these items is to clarify what the plan involves, as well as to assess their intent or likelihood of acting on the plan. Record the response verbatim where possible.

Item 9: Protective factors

This open-ended item explores what has stopped the person from acting on suicidal thoughts. The purpose of this question is to identify protective factors or deterrents. Examples may be provided if helpful, but responses should not be led. This item is optional. If the person is unable to identify any protective factors, this should be recorded clearly, as absence of protective factors

contributes to category coding.

Item 10-10b: Access to support networks

The purpose of this item is to assesses whether the person has people or services they could contact for support. This item informs understanding of social and practical supports available to the person, as well as the feasibility of accessing these supports when needed. Responses to these items should be recorded verbatim, as they may inform ongoing safety and support planning.

Item 11: Reasons for living

This final item explores whether the person can identify any reasons for living through open-ended responses. This item contributes to the assessment of protective factors, so if the person is unable or unwilling to identify reasons for living, this should be recorded this clearly.

Suicide Assessment Kit - Modified Interview (SAK-MI)

Please indicate if you completed the questions by yourself, or with the help of someone else

By myself	With the help of someone else*	*Relationship (e.g. parent)

1 Think about the last 4 weeks. Did you feel so sad that nothing could cheer you up or make you happy?

Sad: feeling down, unhappy

None of the time	A little of the time	Some of the time	Most of the time	All of the time

2 Think about the last 4 weeks. How often did you feel that something was going to happen that would make you happy?*

*reverse score due to re-phrasing of question from original

None of the time	A little of the time	Some of the time	Most of the time	All of the time

3 Think about the last 4 weeks. How often did you feel intense **shame** or **guilt**?

Shame: a feeling that people have when they have done, said or thought things that made them feel bad or upset.

Guilt: when someone thinks they have done something wrong, and they feel bad about it.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
4	In the past 4 weeks, how often did you feel worthless?				
	Worthless: something that has no value. When someone feels useless or like they have no value				

	None of the time	A little of the time	Some of the time	Most of the time	All of the time

5	Have you ever tried to kill yourself?		
	Yes		No
5a	(if yes to Q5) How many times have you tried to kill yourself?		
	One time	Two times	Three or more times
5b	(if yes to Q5) How long ago did you last try to kill yourself?		
	In the past 2 months	2-6 months ago	6-12 months ago
	1-2 years ago	More than 2 years ago	I don't remember
6	Is something bad that happened to you still making you feel bad now?		
	Yes		No
6a	(if yes to Q6) Are any of these areas of your life still making you feel bad? Please select any areas which might be making you feel bad.		
	Family breakdown	Breaking up with a partner, parents getting divorced, siblings moving away	
	Relationship problems	Having regular arguments with your partner, having regular arguments with your family members, communication problems with your family/partner	
	Personal loss/ grief	Someone you love has died	
	Conflict relating to your sexual orientation	**Sexual orientation:** Includes gay/lesbian, bisexual, asexual, polyamorous, and others	

Conflict relating to your gender identity	**Gender identity:** The gender you feel you are inside which might not be the same as the gender you are on the outside. Or you might not feel like either a boy or a girl
Legal problems	Being in trouble with the police or needing to go to court
Child custody issues	**Child custody:** Being able to see your children
Chronic pain/ illness	**Chronic**: Very bad
Trauma	A very strong shock or very upsetting experience
Bullying	**Bullying:** Teasing, hurting or being mean to someone
Other (please specify):	

7 Have you thought about killing yourself in the past 4 weeks?

If the answer is No, skip to Q10.

Yes	No

7a (if yes to Q7) In the past 4 weeks, how often have you had thoughts of killing yourself?

None of the time	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**

7b (if yes to Q7) Think about how long you have been having thoughts about killing yourself. For example, think whether you have only had thoughts about killing yourself in the past 4 weeks, or if you have had thoughts like these before.

How long have you been thinking about killing yourself?

In the past 4 weeks only	Within the past 6 months	
Within the past 6 - 12months	For more than 12 months	Don't know

7c (if yes to Q7) How strong are thoughts about killing yourself?

	Not strong at all	Somewhat strong	Strong	Very strong	? Don't know

Not strong at all: Choose this answer if you don't think about killing yourself much

Somewhat strong: Choose this answer if thoughts about killing yourself happen some of the time and are upsetting

Strong: Choose this answer if thoughts about killing yourself happen often or make you feel serious about killing yourself

Very strong: Choose this answer if you think about killing yourself a lot and you have trouble thinking about anything else

7d (if yes to Q7) How strong have these thoughts of killing yourself been in the last week?

	Not strong at all	Somewhat strong	Strong	Very strong	? Don't know

Not strong at all: Choose this answer if you don't think about killing yourself much

Somewhat strong: Choose this answer if thoughts about killing yourself happen some of the time and are upsetting

Strong: Choose this answer if thoughts about killing yourself happen often or make you feel serious about killing yourself

Very strong: Choose this answer if you think about killing yourself a lot and you have trouble thinking about anything else

8 (if yes to Q7) Do you have a plan for how you would attempt to kill yourself?

Yes	No

8a(i) (if yes to Q8) What is your plan to kill yourself?

8a(ii) (if yes to Q8) Are you able to access or get the things you need to carry out your plan of killing yourself?

	Yes	No

8b(i)	(if yes to Q8) *Where* would you attempt to kill yourself?

8b(ii)	(if yes to Q8) Have you finished making all the necessary preparations to carry out your plan to kill yourself?

	Preparations: having things ready	
	Yes	No

8c	How likely are you to act on this plan to kill yourself?

				?
Very unlikely	**Unlikely**	**Likely**	**Very likely**	**Don't know**

9	What has stopped you acting on your suicidal thoughts?

Examples:

Thinking about who will take care of your pet.

Thinking about things you enjoy doing that you wouldn't be able to do.

If you can, try and identify at least one thing that has stopped you acting on your thoughts to kill yourself.

10	Do you have one person, or a few people who you can go to if you need help?

	Yes		No
	Examples of people who could help or support you:		
	Friend	Emergency helpline	Health professional	Teacher
	University professor	Counselor	Physician, doctor, or GP (general practitioner)	

10a	(if yes to Q10) Who is/are this/these person/people?

10b	(if yes to Q10) How often are you in contact with this/these person/people?		
	Daily	A few days a week	Weekly
	Monthly	Less than once a month	

11	What helps you when things are difficult or when you are feeling down, sad or depressed?

Examples:

Sometimes when people feel sad, or when things are difficult, they may find it helpful to talk to their pet.

Some people may make time to play an online game, or go for a walk.

Try to identify at least one thing that helps you. It's ok to identify more than one thing - try to think of the things that are most helpful to you.

Scoring and Interpretation

How to score the SAK-MI

Clinicians should refer to the coding algorithm to score the SAK-MI. Where a response seems like it could fit in more than one category, a conservative approach is recommended where the higher ranked category is selected in favour of a lower category. As with any psychological instrument, resultant scores and categories should only be interpreted in conjunction with other relevant information to form an overall impression which can be used to guide clinical decision making.

CAUTION: It is the position of the authors that any identified or reported history of suicidal thoughts and behaviour immediately places the individual at potential risk of a suicide attempt. Similarly, failure to report or identify a history of suicidal thoughts and behaviour does not mean the individual is not capable of a future suicide attempt. Developing a neuroaffirming, psychologically safe environment that prioritises trust and collaborative care is essential to support open disclosure of sensitive topics such as suicidal thoughts and behaviour.

The SAK-MI produces two primary outcomes:

1. Negative Affect score

Scores between 6-9 indicate possible depression, while scores of 10 or higher indicate likely depression. This score provides a dimensional index of emotional distress and can be used to guide further assessment of mood symptoms.

2. SAK-MI ordinal categories (1-5)

The SAK-MI coding algorithm assigns individuals to one of five ordinal categories based on their responses and reflecting the severity and chronicity of suicidal thoughts and behaviour:

- **Category 1**: No reported suicidality; minimal stressors; protective factors present
- **Category 2**: Low-level suicidal ideation; no plan; protective factors present
- **Category 3**: Suicidal ideation with additional risk factors; some protective factors present
- **Category 4**: Suicidal ideation with plan and/or recent or multiple attempts; few protective factors
- **Category 5**: Presence of plan and preparations; absence of protective factors; unwillingness to disclose details; high acuity

Importantly, the SAK-MI is not designed to stratify people into "low," "moderate," or "high" risk categories and should not be relied on as a predictor of suicide attempts. Indeed, in most cases it is very difficult to accurately predict a suicide attempt. Consistent with best-practice recommendations against risk stratification (National Suicide Prevention Office, 2025), the SAK-MI categories are intended to support clinical decision-making and prioritisation of care rather than prediction of a suicide attempt.

Wherever suicidal thoughts or behaviour are identified, clinical intervention is recommended. The SAK-MI coding algorithm includes suggested follow-up actions for each category (e.g., monitoring, suicide safety planning, involvement of supports, or triage to emergency care). All actions should be guided by professional judgement and aligned with organisational policies and national guidelines.

Psychometric properties

SAK-MI was validated in a sample of 98 autistic adults without intellectual disability (58% women, 34% men, 7% non-binary; Mage = 41.65 years, SD = 12.96). In this study, participants completed a battery of self-report suicide and mental health measures at baseline, followed by administration of the SAK-MI as a structured clinical interview approximately 111 days later.

Internal consistency of the four-item Negative Affect scale (items 1-4) was adequate (McDonald's ω = .80, 95% CI .71-.86), indicating that these items reliably measure a single underlying construct of emotional distress.

The SAK-MI demonstrated strong convergent validity, with the ordinal SAK-MI category score (Categories 1-5) correlating with established suicide and mental health measures, including the Suicidal Ideation Attributes Scale - Modified (p = .63), Suicidal Behavior Questionnaire - Revised (p = .70), and multiple indices of the Columbia-Suicide Severity Rating Scale (severity p = .58; intensity p = .62; suicidal behaviour p = .65). The Negative Affect score also showed strong associations with depression, anxiety, and stress (PHQ-8 and DASS-21).

Divergent validity was supported by non-significant correlations with the COVID-19 Impact Scale, indicating that the SAK-MI measures suicidal distress rather than general situational stress.

Receiver operating characteristic analyses demonstrated strong discriminative accuracy for identifying individuals assessed by clinicians as being above low risk of future suicide attempt (AUC = 0.89). Using a cut-off of Category 4 or higher, the SAK-MI showed high specificity (0.90) and good sensitivity (0.75) for identifying individuals requiring additional clinical intervention.

Further reading

Hedley, D., Williams, Z. J., Deady, M., Batterham, P. J., Bury, S. M., Brown, C. M., Robinson, J., Trollor, J. N., Uljarević, M., & Stokes, M. A. (2025). The Suicide Assessment Kit-Modified Interview: Development and preliminary validation of a modified clinical interview for the assessment of suicidal thoughts and behavior in autistic adults. Autism, 29(3), 766-787. https://doi.org/10.1177/13623613241289493

Deady, M., Ross, J. & Darke, S. (2015). Suicide Assessment Kit (SAK): A comprehensive assessment and policy development package. Sydney: National Drug and Alcohol Research Centre.

Suicide Assessment Kit-Modified Interview (SAK-MI) coding algorithm

Category/ description	Coding	Suggested action
NEGATIVE AFFECT	Sum first four items (0-4 scale for each item, total of 16 points) Questions 1, 3, 4: ▪ 0 = None of the time ▪ 1 = A little of the time ▪ 2 = Some of the time ▪ 3 = Most of the time ▪ 4 = All of the time Question 2 is reverse scored: ▪ 4 = None of the time ▪ 3 = A little of the time ▪ 2 = Some of the time ▪ 1 = Most of the time ▪ 0 = All of the time Scores between 6-9 indicate possible depression (high sensitivity), 10+ indicate likely depression (high specificity)	Monitor, assess for possible depression
CATEGORY 1		
History of suicidality absent, current stressors absent, ideation absent, support networks present, may have elevated negative affect score.	▪ Item 5 (Lifetime attempts) = "No" AND ▪ Item 6 (Current stressor) = "No" OR < 3 stressors on item 6a endorsed) AND ▪ Item 7 (Current ideation) = "No" AND ▪ Item 10 (Support network) = "Yes" AND ▪ Item 11 (Coping skills) identified.	Monitor, assess for possible depression

CATEGORY 2		
Current low-level Suicidal Ideation (SI) in the absence of plan, reason to live present, support network and coping skills identified.	▪ Item 5 (Lifetime attempts) = "No"* AND ▪ Item 6 (Current stressor) = "No" OR < 3 stressors on item 6a endorsed) AND ▪ Item 7 (Current ideation) = "Yes" AND ▪ Item 7a = "None of the time," or "A little of the time," AND ▪ Item 7c = "Not strong at all" or "Somewhat strong" AND ▪ Item 7d = "Not strong at all" or "Somewhat strong" AND ▪ Item 8 (Plan) = "No" AND ▪ Item 9 (Reasons to Live) identified AND ▪ Item 10 (Support network) = "Yes" AND ▪ Item 11 (Coping skills) identified. *Also code here if respondent has a history of a remote attempt (≥ 2 years prior) in the absence of current SI or other risk factors	Monitor, assess for possible depression. Investigate therapeutic intervention based on client preference and level of distress caused by ideation. Discuss developing a safety plan and provide resources
CATEGORY 3		
Presence of Suicidal Ideation (SI) with additional risk factors, some protective factors present, support network present.	▪ Item 7 (Current ideation) = "Yes" AND any of the following ▪ Item 7a = "Some of the time" ▪ Item 7c = "Strong" ▪ Item 7d = "Strong" ▪ 3 + stressors endorsed on item 6a, ▪ Item 8 (Plan) must be "No" (if plan, automatically high risk), ▪ Item 5 (Lifetime attempts) = "No" or 1 attempt at least 1 year in the past allowed in this category; past-year attempt automatically Category 4 or Category 5, ▪ Must still have 2/3 protective factors, ▪ Item 9 (Reasons to Live) identified, ▪ Item 10 (Support network) = "Yes" ▪ Item 11 (Coping skills) identified.	Monitor, assess for possible depression. Investigate therapeutic intervention based on client preference and level of distress caused by ideation. Discuss developing a safety plan and provide resources.

CATEGORY 4		
Presence of Suicidal Ideation (SI), history (HX) of attempts (maybe recent or multiple past attempts), presence of plan, few protective factors, support network not identified.	▪ Item 7 (Current ideation) = "Yes" AND any of the following: ▪ Item 7a = "Most of the time" or "All of the time" ▪ Item 7c = "Very strong" ▪ Item 7d = "Very strong" ▪ Recent attempt within past year (item 5b) and/or multiple past attempts (item 5a) ▪ Item 8 (Plan) = "Yes" ▪ includes detailed answers for items 8a (i) and/or 8b (i) (specific plan and location) and/or means that are accessible at some point in the future (item 8a (ii)) ▪ 0 or 1 protective factors ▪ Item 8c = "very unlikely" or "unlikely" ▪ Item 9 (Reasons to Live) not identified AND ▪ Item 10 (Support network) = "No" AND ▪ Item 11 (Coping skills) not identified.	Develop a safety plan and provide crisis resources. Discuss safety if returned home, consider informing family member or other support person if there are any safety concerns.
CATEGORY 5		
Presence of plan, preparations, maybe unwilling to disclose details of plan, absence of protective factors or support network, unable to identify any reason to live.	▪ Item 8 (Plan) = "Yes" AND any of the following ▪ Unwilling to disclose details of suicide plan (items 8a/b (i)) ▪ Item 8b (finished making preparations) = "Yes" ▪ Item 8c = "likely", "very likely" or "don't know" ▪ No protective factors ▪ Item 9 (Reasons to Live) not identified AND ▪ Item 10 (Support network) = "No" AND ▪ Item 11 (Coping skills) not identified	Admit to hospital. Monitor and restrict access to means.

SAK-MI Visual Response Scales

Administration notes:

Visual response scales may be provided to respondents prior to administering the SAK-MI to support comprehension and response accuracy. Use of these scales is optional and not required to complete the SAK-MI. Administering healthcare professionals should ask about individual preferences and use visual supports where they are helpful.

Scale 1 applies to SAK-MI questions 1, 2, 3, 4 and 7a.

1

None of the time	A little of the time	Some of the time	Most of the time	All of the time

Scale 2 applies to SAK-MI questions 7c and 7d.

2

				?
Not strong at all	Somewhat strong	Strong	Very strong	Don't know

Scale 3 applies to SAK-MI question 8c.

3

				?
Very unlikely	Unlikely	Likely	Very likely	Don't know

3 Autism Adapted Safety Plan (AASP)

Jacqui Rodgers, Sarah Cassidy, Mirabel Pelton, Jane Goodwin, Emma Nielsen, Janelle Wagnild, Nawaraj Bhattarai, Isabel Gordon, Colin Wilson, C., Phil Heslop, Emmanuel Ogundimu, Rory C. O'Connor, Sheena E. Ramsay, Ellen Townsend, & Luke Vale (2024)

About the AASP

The Autism Adapted Safety Plan (AASP; Goodwin et al., 2025; Rodgers et al., 2023, 2024) is a collaborative suicide prevention tool designed to support autistic adults without intellectual disability who experience suicidal thoughts, behaviour, and self-harm. The AASP builds on established safety planning approaches used in the general population through a series of autism-specific adaptations that were co-designed by autistic adults, family members, healthcare professionals, and autism researchers to improve the accessibility, relevance, and usability of safety planning for autistic adults.

Several studies evaluating the AASP have found that autistic adults often require clearer instructions, concrete examples, and structured supports to complete safety plans effectively. These include explicit explanations of the purpose of each step, clear examples, and practical tools to support identification of emotions, bodily cues, and signs that distress may be escalating. With such modifications, the AASP is demonstrated to be feasible, acceptable, and experienced as useful by autistic adults and those supporting them.

While research indicates that many autistic adults benefit from the support of a trusted person when developing an AASP, the safety planning process should also be responsive to an individual's communication needs and preferences, sensory processing differences, and lived experience. For healthcare professionals, this means that developing an AASP alongside an autistic client may require flexibility in pacing and structure, including completing it across multiple sessions (e.g., three 30-minute sessions).

Aims of the AASP

- Support early recognition of escalating distress.
- Identify personalised internal and external coping strategies.
- Increase the safety of an individual's environmental.
- Clarify who to contact and how to access help during periods of increased risk.
- Provide a concrete, accessible plan that can be referred to during crisis.

Intended age range

- The AASP was originally developed with and for autistic adults (18 years+), but many aspects of AASP could also be useful for autistic young people. AASP is about personalising safety planning to meet an individual's needs. Professionals should therefore consider the needs of the autistic person they support regardless of chronological age, and whether AASP could be useful

to the autistic person.

- When used in clinical settings, healthcare professionals may need to consider the developmental age of the respondent prior to administering the instrument. For adults with a developmental age <18 years, caution is recommended, and clinical judgement should be used to determine whether the questions are appropriate for the individual or not.

When to develop an AASP

An AASP is ideally developed before a crisis arises, but can also be developed when suicidal thoughts or behaviour are present (e.g., SIDAS-M score ≥ 1), when a person reports prior suicide attempts, self-harm, or suicide-related distress (even if intermittent), or when a person requests support to manage their mental health.

An AASP can be developed in two formats:

- **Paper-based plan**: The AASP template can be downloaded and printed for use as a paper-based safety plan.
- **Online form**: The AASP template can also be completed using an online form. Once completed, the form will generate a PDF copy that can be printed or saved locally on your device. Information entered into the online form is not saved by the span.toolkit website and is not accessible to other users. Please note that the online AASP form is hosted externally, so users should review the host website's privacy policy before developing a plan.

CAUTION: It is the position of the authors that an AASP should not be used in isolation or as a replacement for any components of existing suicide risk management protocols. Instead, the AASP should be considered an adjunct support for autistic adults within the context of ongoing care provided by a qualified healthcare professional.

Instructions for using the AASP

Before commencing

- Ask if the person would like to develop an AASP independently or with support.
- Emphasise that an AASP is intended to support the person's safety during times of crisis.
- Provide access to the additional resources designed to assist with identification of triggers or warning signs that distress is escalating. These are not required to complete an AASP, so ask about individual preferences.

- Allow as much time as needed to complete the AASP, and offer breaks, pauses or options to complete it across multiple sessions.

How to develop an AASP

An Autism Adapted Safety Plan is designed to be created by a person who is at risk of self-harm or suicide, ideally before they are in crisis. The plan outlines a series of steps the individual can follow to help keep themselves safe during times when urges to self-harm or thoughts of suicide increase. Importantly, an AASP is personal and should be written in the individual's own words. A person may choose to develop a safety plan independently, or with the support of a trusted person such as a healthcare professional, friend, family member, or support worker.

The AASP uses a multi-step template for gathering and recording important information:

- **What is important to me?** The first section prompts a person to identify something individually meaningful that they can focus on when feeling unsafe.
- **Step 1.** Focuses on Identifying warning signs that may precede strong thoughts, feelings or urges to self-harm or attempt suicide.
- **Step 2.** Involves identifying what can be used as a positive distraction when distress is escalating.
- **Step 3.** Identifies people who can be contacted for help and their availability to respond during a crisis (e.g., family, friends, mentor, support worker).
- **Step 4.** Focuses on identifying professionals or agencies that can be contacted during a crisis and their availability (e.g., help lines, healthcare professionals, emergency departments).
- **Step 5.** Involves determining what changes can be made to increase the safety of the person's environment (e.g., removing items that could be used in harmful ways).
- **Step 6.** Prompts the person to identify actions that others can take to provide support.
- **Step 7.** Encourages the person to share their safety plan with trusted people including friends, family, and healthcare professionals.

Additional Resources

A range of optional resources are provided with the AASP to help people identify, describe, and communicate their internal experiences and support needs. These include guides for exploring how distress is experienced, such as lists of emotions, a feelings wheel, and prompts to identify where emotions are felt in the body. A variety of example rating scales are also available to help people communicate levels of distress or safety in ways that make sense to them, including horizontal scales, thermometer-style scales, emoji-based scales, number scales, colour scales, and blank templates that allow individuals to create personalised scales that feel useful to them.

In addition, practical resources are included to help people identify where they can go for support, including space to list trusted contacts, support services, and personalised self-care or coping strategies. These resources are intended to be flexible and can be used, adapted, or omitted according to individual preferences and needs.

Further reading

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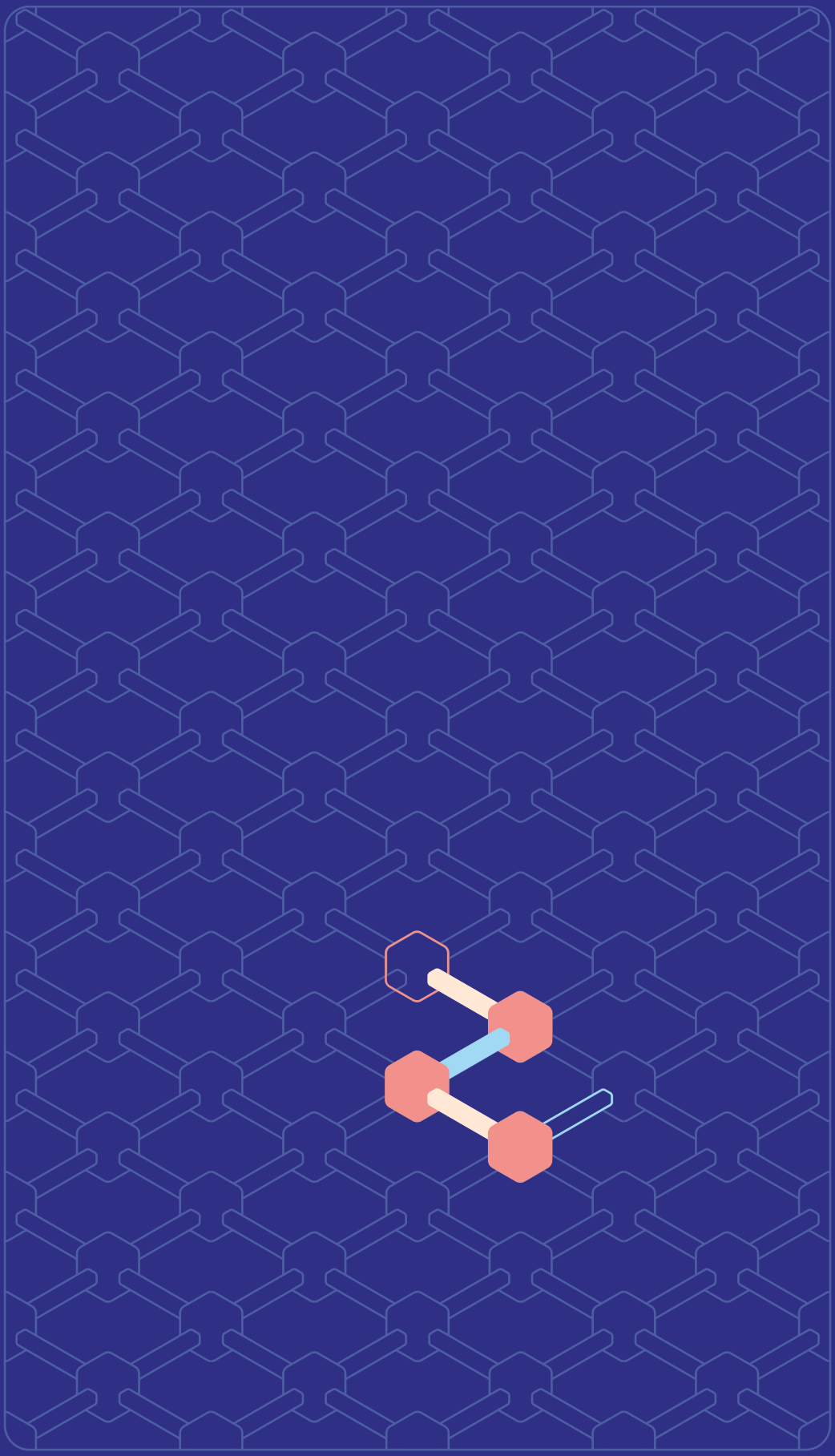

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