



# Mental Health Clinicians' Screening and Intervention Practices to Reduce Suicide Risk in Autistic Adolescents and Adults

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## Abstract

Autistic individuals experience elevated risk for suicide ideation, attempts, and deaths. Little is known about how clinicians assess risk or intervene with suicidal autistic individuals. We surveyed 121 clinicians about use of suicide prevention practices with autistic and non-autistic clients. Clinicians reported greater self-efficacy in screening for suicide risk among non-autistic clients ( $p=0.01$ ). There were no statistically significant differences in whether they used standardized screening measures or in their reported normative pressure or attitudes towards screening. Clinicians reported similar rates of use of Safety Planning, an evidence-based suicide-prevention strategy, across groups, but greater acceptability for non-autistic clients ( $p<0.001$ ). These findings have implications for strategies to increase clinicians' adoption of these tools for autistic individuals.

**Keywords** Suicide · Autism spectrum disorder · Screening · Safety planning intervention

## Introduction

More than 800,000 people die by suicide each year (World Health Organization 2019). In the United States, suicide is the 10th leading cause of death overall and the second leading cause of death for youth aged 10–24 years (Centers for Disease Control and Prevention 2019). Autistic individuals are at elevated risk for suicidal ideation and behavior, and for deaths by suicide. Autistic individuals are up to nine times more likely to experience suicidal ideation and up to six times more likely to attempt suicide than age- and sex-matched controls (Cassidy et al. 2014; Chen et al. 2017; Croen et al. 2015; Segers and Rawana 2014). Population-level data from Sweden suggest that autistic individuals were

over 7.5 times more likely to die by suicide than matched general-population controls (Hirvikoski et al. 2016). In the first statewide (Utah) U.S population-based study of suicide in autistic individuals, Kirby et al. (2019) found that autistic females were more than five times more likely to die by suicide than neurotypical peers between the years of 2013 and 2017. Despite their increased risk for suicide, little research has examined how to effectively identify or mitigate suicide risk in autistic individuals.

An important first step in preventing suicide is to identify those at risk. Although some screening tools, such as the ninth question of the Patient Health Questionnaire (PHQ; Spitzer et al. 1999), have been found to predict suicide attempts and deaths over time in non-ASD specific samples (e.g., Louzon et al. 2016; Simon et al. 2016), other research suggests that many screening tools do not accurately predict risk of suicide (e.g., Carter et al. 2017; Wang et al. 2016). Nonetheless, the Joint Commission (2019), the largest health care accrediting body in the United States, now requires the use of validated tools to screen for suicide risk (e.g., PHQ; Columbia Suicide Severity Rating Scale [C-SSRS, Posner et al. 2011]) in all individuals treated or evaluated for behavioral health conditions as their primary reason for care. The extent to which screening is implemented with autistic clients remains unknown, as is the effectiveness of these tools in identifying suicide risk in this population. Autistic

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individuals have typically been excluded from screening validation studies (Horowitz et al. 2018). This gap in the literature is concerning given that experiences associated with autism, such as challenges in identifying and communicating self-states and understanding abstract concepts of death and dying, may affect efforts to identify suicide risk (Horowitz et al. 2018). Screening tools for other co-occurring psychiatric disorders, such as depression and anxiety, have been successfully modified for use with autistic individuals (e.g., Leyfer et al. 2006). Research examining the effectiveness and potential need for adaptation of screening tools for suicide risk, such as the Ask Suicide-Screening Questions (ASQ; Horowitz et al. 2012) and the Suicidal Behaviors Questionnaire-Revised (SBQ-R; Osman et al. 2001; Cassidy et al. 2019), is currently underway.

Research on interventions for mitigating suicide risk in autistic individuals is even more scant. To date, no interventions have been empirically tested. Interventions targeting other co-occurring psychiatric disorders, such as cognitive behavioral therapy for anxiety, have been successfully modified to treat autistic children, adolescents, and adults (e.g., Kerns et al. 2016; White et al. 2017; White et al. 2018). Whether existing evidence-based practices for suicide prevention can also be modified to treat autistic individuals experiencing suicidal thoughts and behaviors remains an empirical question.

The Safety Planning Intervention (SPI; Stanley and Brown 2012) is one evidence-based suicide prevention intervention with the potential to be a good fit for autistic individuals who experience suicidal thoughts or behaviors. SPI is a brief clinical intervention designed to lower the short-term risk of suicide. The rationale behind SPI is that the urge to act on suicidal thoughts is typically very brief, and if individuals can refrain from acting during this brief period, their risk of engaging in suicidal behaviors will diminish. The clinician and individual collaborate to create a stepwise plan that contains an easy-to-read list of individually tailored, concrete coping mechanisms to be enacted during or leading up to a crisis. Given that problem-solving capacity diminishes during or preceding a crisis, the Safety Plan is designed to be clear, concise (one page), and easy to use. The stepwise nature of the plan provides a roadmap for the user; if one step is not effective in reducing suicidal thoughts or urges, the user will then move on to the next step. The coping strategies are initially “within self” (i.e., do not require other people to implement) to encourage self-efficacy. As the steps progress, reliance on external forces for intervention increases, culminating in seeking emergency care. Several aspects of SPI, including the fact that it is a written plan with concrete steps and visual prompts, suggest that it may be compatible with the learning style of many autistic people.

In neurotypical individuals, SPI has been associated with reduced suicidal behavior (Bryan et al. 2017; Stanley et al. 2018) and ideation (Bryan et al. 2017), and increased treatment engagement (Stanley et al. 2018). Studies also show that both clinicians and clients find SPI acceptable and feasible to implement (Chesin et al. 2017; Stanley et al. 2016). Little is known, however, about whether clinicians perceive SPI to be acceptable for autistic individuals or the extent to which they implement it with these clients. Obtaining this information is an important first step in determining if and how SPI should be adapted for autistic individuals and the clinicians who work with them.

Although there is a critical need for suicide prevention practices validated for autistic individuals, until they are developed, tested, and disseminated, clinicians are tasked with screening and intervening in their absence. There is a need to understand the current landscape of clinicians’ suicide prevention practices for autistic individuals and whether clinicians are using and/or adapting currently available screening and intervention tools with their autistic clients. While the development and validation of suicide prevention practices for autistic individuals is in progress, concurrently examining factors that may influence clinicians’ use of these practices can inform the development of implementation strategies to accelerate the pace of adoption when these tools become available.

The present study examined clinicians’ attitudes and behaviors around suicide prevention in autistic individuals. Our primary aims were: (1) to examine clinicians’ use of and beliefs about suicide risk screening practices for autistic adolescents and adults in comparison to adolescents and adults without autism; and (2) to examine clinicians’ knowledge of and confidence in using SPI with autistic clients relative to clients without autism.

## Methods

### Procedures

[Institution redacted for blind review]’s Institutional Review Board approved the study procedures. To recruit our sample, we emailed directors of community mental health agencies, agencies specializing in serving autistic individuals, a developmental and behavioral pediatric clinic, a master’s program in mental health counseling, and a professional membership organization that represents more than 45 independent community mental health agencies in Southeastern Pennsylvania. We asked the directors to share the secure web link to the electronic survey with all clinicians who work with adolescents or adults with autism.

Informed consent was obtained from all individual participants included in the study prior to beginning the survey

and after reading a description of the study and its purpose. Participants completed a confidential online survey accessed through a secure web link, which took approximately 15 minutes to complete. Participants received a \$20 gift card upon completion of the survey.

## Measure

Because there are no validated tools for assessing clinicians' attitudes about and use of suicide screening and intervention practices for autistic adolescents and adults, we created a survey (see [Appendix](#)). The survey instructed clinicians to answer questions about the prevalence of suicidal thoughts and behaviors in non-autistic clients and autistic clients, as well as use, attitudes, self-efficacy, and perceived injunctive norms (or the perception of how others expect them to behave) related to standardized screening measures for suicide risk.

To assess clinician use of standardized screening measures, participants were asked whether (yes/no) they use any standardized screening measure to identify suicide risk in clients without autism, as well as whether they use any of the following screening tools: the Columbia Suicide Severity Rating Scale (C-SSRS, Posner et al. 2011); ASQ (Horowitz et al. 2012); Beck Depression Inventory (BDI; Beck et al. 1996); Patient Health Questionnaire (PHQ-9; Spitzer et al. 1999); and the Self-Injury Thoughts and Behavior Interview (SITBI; Nock et al. 2007). Respondents also could write in other measures not listed.

We used procedures from social psychology as a guide to measure attitudes, norms, and self-efficacy (Fishbein and Ajzen 2010). We used item stems intended to be adapted for modification to any target behavior. Other studies have adapted these stems and shown adequate to excellent psychometric properties (Fishbein and Ajzen 2010; Fishman et al. 2019). Specifically, to assess attitudes, we used the semantic differential technique, which asks participants to evaluate the favorability of a specific behavior (e.g., screening for suicide risk) using adjective pairs at opposite poles on a continuum. We used “bad” and “good” as the evaluative dimension on an 11-point standard semantic differential scale to assess negative vs. positive attitudes about screening for suicide risk. To measure perceived injunctive norms, clinicians rated the degree to which they believe others important to them would approve of them screening for suicide risk. Clinicians responded to three different statements, reflecting the approval of other clinicians, supervisors, and clients using a five-point scale ranging from “disapprove” to “strongly approve.” We computed a total injunctive norms score by averaging these three items. In our sample, internal consistency for the injunctive norms questions about clients with and without autism was good to excellent ( $\alpha = 0.81$  and 0.90, respectively). Self-efficacy was conceptualized as

clinicians' beliefs in their ability to screen for suicide risk using a 5-point scale ranging from “very sure I cannot” to “very sure I can.”

The survey also asked about clinicians' familiarity with SPI, and SPI use and acceptability with autistic and non-autistic clients. Participants were presented with a brief description of SPI and asked to indicate whether they had heard of it, received focused training in it, and used it with clients. To assess acceptability of SPI, clinicians indicated the degree to which they agree (0 = Strongly disagree, 10 = Strongly agree) with the following statement: “Using the Safety Planning Intervention as a suicide prevention strategy with individuals without autism would be acceptable to me.”

The survey concluded with a brief section focused on clinicians' demographic characteristics, such as age, race/ethnicity, and gender, as well as professional characteristics, including educational background, setting in which they work, and percentage of autistic clients on their caseload.

## Analyses

We used IBM SPSS Statistics Version 25 to analyze all study data. First, we calculated descriptive statistics for participant characteristics and clinical experiences. Next, to compare participants' ratings for autistic and non-autistic clients, we used paired t-tests for continuous data, Wilcoxon signed-ranks tests for ordinal data, and exact McNemar's tests for nominal data.

## Results

### Participants

One hundred seventy-three clinicians started the survey and 121 clinicians completed it. Because demographic questions were presented at the end of the survey, we cannot estimate differences between those who completed and those who did not complete the survey. Of the 52 participants who did not complete the survey, 41 answered zero survey questions following the consent form (i.e., they opened the survey but did not complete any items). An additional 11 participants answered at least one survey question but did not complete the survey; these individuals also did not provide an email address, which was required to deliver study compensation. Because these individuals were not compensated for their participation, we did not include their data in any analysis.

Table 1 presents information pertaining to demographics and clinical background and experiences of our final sample ( $n = 121$ ). The majority (51%) of participants worked in community mental health settings, with autism specific clinics as the second most common work setting (20%). The

**Table 1** Participant characteristics (n = 121)

	N (%) or Mean (SD)
Sex	
Female	100 (83%)
Male	21 (17%)
Age	36.98 (9.79)
Race/ethnicity <sup>a</sup>	
Hispanic/Latino(a)	6 (5%)
Asian	8 (7%)
Black/African American	40 (33%)
Middle Eastern	1 (1%)
White	70 (58%)
Other	2 (2%)
Educational background	
College degree	18 (15%)
Master's degree	89 (74%)
Doctorate in clinical psychology	10 (8%)
Medical degree	4 (3%)
Years since highest degree	8 (.67)
Licensed	57 (47%)
Fee-for-service provider	39 (32%)
Trainee	10 (8%)
Percent of clients with ASD diagnosis	
0%	19 (16%)
1–21%	45 (38%)
21–50%	22 (18%)
51% or greater	35 (29%)
Clinical setting	
Autism-specific clinic	24 (20%)
Community mental health agency	62 (51%)
Developmental pediatric clinic	1 (1%)
Hospital unit or residential setting	12 (10%)
School-based setting	10 (8%)
Other	12 (10%)

<sup>a</sup>Participants were asked about ethnicity (Hispanic/Latino(a)) and race separately. Thus, n = 127 in this section because the six participants who identified as Hispanic and Latino also identified a race with which they affiliated

remaining clinicians worked in hospital or residential settings (10%), school-based settings (8%), a developmental and pediatric clinic (1%), and other settings (10%), which included outpatient mental health private practices. With regard to training, the majority (74%) of participants had master's degrees in various fields, including social work, applied behavior analysis, counseling or clinical psychology, and family therapy.

A subset (n = 19) of participants reported zero autistic clients on their current caseloads. These participants were not included in analyses addressing use of screening and intervention practices (e.g., “Do you use a standardized measure to screen for suicide risk in your clients with autism?”).

However, their data were used for analyses related to self-efficacy, attitudes, acceptability, and perceived norms.

Table 2 presents: participant-reported percentages of their autistic and non-autistic clients perceived to be at risk for suicide; ratings of use, attitudes, normative pressure, and self-efficacy related to standardized screening measures with autistic and non-autistic clients; and use and acceptability of SPI with autistic and non-autistic clients.

Clinicians reported statistically significant differences in rates of elevated suicide risk in autistic clients and clients without autism ( $Z = -2.45, p = 0.01$ ). Specifically, respondents identified a greater proportion of their non-autistic clients as at risk for suicide relative to autistic clients. Most notably, clinicians were more likely to report having no autistic clients at risk for suicide (21%) than no clients without autism at risk for suicide (6%).

There were no statistically significant differences in clinicians' use of any standardized screening measure with autistic clients (57% of clinicians endorsed using a standardized measure) and clients without autism (58%;  $p = 1$ ). The C-SSRS was the most commonly endorsed screening tool across client groups, although a significantly greater number of clinicians reported using the measure with non-autistic clients (26%) than with autistic clients (19%;  $p = 0.04$ ). There were no differences in use of any other screening measure in autistic clients and non-autistic clients (all  $p$  values  $\geq 0.77$ ). Similarly, neither participants' injunctive normative pressure [ $t(120) = 0.20, p = 0.85$ ] nor attitudes towards screening for suicide risk [ $t(120) = 0.43, p = 0.67$ ] varied based on client type. In contrast, clinicians reported greater self-efficacy in screening for suicide in non-autistic clients than in autistic clients [ $t(120) = 2.79, p = 0.01$ ]. Over 76% of clinicians indicated they were “sure” or “very sure” that they could screen for suicide risk with their clients without autism, whereas only 65% endorsed the same responses for autistic clients.

A minority of clinicians (39%) reported having heard of SPI and fewer (21%) stated that they received training in the intervention. Clinicians were equally likely to use SPI with autistic clients (21%) and non-autistic clients (27%;  $p = 0.27$ ). After reading a description of SPI, clinicians reported greater acceptability for clients without autism relative to autistic clients (see Table 2; [ $t(120) = 4.55, p < 0.001$ ]).

## Discussion

To our knowledge, this study is the first to compare clinicians' use of and beliefs about suicide screening practices for autistic adolescents and adults relative to those without autism. It is also the first to examine clinicians' knowledge of and confidence in using a specific evidence-based practice for suicide prevention, SPI, with autistic clients.

**Table 2** Descriptive statistics and within-group comparisons of clinician screening and intervention practices and perceptions for autistic clients and clients without autism

Variable	Clients without autism Mean (SD, range) or N (%)	Autistic clients Mean (SD, range)	Test statistic Z or <i>t</i> (df)	<i>p</i> value
Percent of clients at risk for suicide <sup>a,1</sup>			<b>Z = -2.45</b>	<b>0.01</b>
0%	6 (6%)	21 (21%)		
1–10%	32 (31%)	40 (39%)		
11–20%	16 (16%)	11 (11%)		
21–40%	18 (18%)	11 (11%)		
54–50%	6 (6%)	8 (8%)		
51–100%	6 (6%)	4 (4%)		
Did not respond	18 (18%)	7 (7%)		
Use of any standardized screening measure <sup>a,2</sup>	59 (58%)	58 (57%)		1
Use of specific screening measures <sup>a,2</sup>				
C-SSRS	<b>26 (26%)</b>	<b>19 (19%)</b>		<b>0.04</b>
ASQ	14 (14%)	14 (14%)		1
BDI	10 (10%)	10 (10%)		1
PHQ-9	5 (5%)	6 (6%)		1
SITBI	8 (8%)	6 (6%)		0.77
Other	14 (14%)	13 (13%)		1
Attitudes towards screening <sup>b,3</sup>	6.67 (2.53, 0–10)	6.55 (2.68, 0–10)	<i>t</i> (120)=0.43	0.67
Screening normative pressure <sup>b,3</sup>	4.22 (0.68, 1–5)	4.21 (0.70, 1–5)	<i>t</i> (120)=0.20	0.85
Screening self-efficacy <sup>b,3</sup>	<b>3.99 (0.75, 1–5)</b>	<b>3.19 (0.69, 2–5)</b>	<b><i>t</i>(120) = 2.79</b>	<b>0.01</b>
Use of SPI <sup>a,2</sup>	27 (27%)	21 (21%)		0.27 <sup>2</sup>
SPI acceptability <sup>b,3</sup>	<b>8.08 (2.1, 0–10)</b>	<b>7.07 (2.43, 0–10)</b>	<b><i>t</i>(120) = 4.55</b>	<b>&lt; 0.001</b>

Higher scores indicate more favorable attitudes, greater normative pressure, higher self-efficacy, and greater acceptability. Statistically significant findings ( $p < .05$ ) are in bold

C-SSRS Columbia Suicide Severity Rating Scale, ASQ Ask Suicide-Screening Questions, BDI Beck Depression Inventory, PHQ-9 Patient Health Questionnaire, SITBI Self-Injurious Thoughts and Behaviors Interview, SPI Safety Planning Intervention

<sup>a</sup> $n = 102$

<sup>b</sup> $n = 121$

<sup>1</sup>Wilcoxon signed ranks test

<sup>2</sup>Related-samples McNemar exact test

<sup>3</sup>Paired *t* tests

Although attitudes towards screening did not differ based on client group, participants reported greater self-efficacy in implementing screening practices with non-autistic clients. Given the lack of standardized measures validated for use with autistic clients, it is not surprising that clinicians feel less confident in their ability to effectively screen for suicide risk in their autistic clients. Efforts to adapt screening tools for autistic clients are underway (e.g., Cassidy et al. 2019), and it is possible that self-efficacy will increase when these measures are available.

Less than half of participants had heard of SPI. This finding was unexpected given that multiple suicide prevention organizations consider it a best practice. Even fewer participants reported using the intervention, with lower rates of acceptability and use with autistic clients than with

non-autistic clients. This discrepancy may reflect the lack of research examining the effectiveness of SPI for autistic individuals. Further research is needed in order to determine the acceptability and effectiveness of the intervention with autistic individuals, as well as the need for modifications for use with autistic individuals. In addition, work focused on understanding barriers to clinician implementation of SPI with autistic clients is indicated. Possible adaptations to the intervention, as well as strategies to address barriers to implementation, should be informed by all stakeholder groups who would be affected by the implementation of such an intervention, including clinicians, autistic clients, and their families. Our team is currently partnering with members of these stakeholder groups to adapt SPI in an iterative manner and pilot the adaptation for autistic individuals



based on findings from this study, qualitative interviews, and literature on adapting mental health interventions for autistic people.

Clinicians identified a greater proportion of their non-autistic clients at elevated risk for suicide than their autistic clients, and were much more likely to say that an autistic client had no risk for suicide. These findings stand in contrast to recent literature indicating that autistic individuals experience suicidal thoughts and behaviors at higher rates than others even when controlling for co-occurring psychiatric diagnoses (Cassidy et al. 2014; Chen et al. 2017; Croen et al. 2015; Hirvikoski et al. 2016; Kirby et al. 2019; Segers and Rawana 2014). The design of the current study precluded us from verifying the accuracy of these clinicians' estimates of risk and determining whether suicide risk was under-detected in their autistic clients. Future research to determine whether clinicians indeed underestimate suicide risk in autistic clients, and if so, potential explanations for why this might be the case (e.g., clinician biases), is indicated in order to inform strategies to increase the adoption and penetration of screening practices with autistic clients.

Fewer than 60% of clinicians reported using any standardized screening measure to assess suicide risk with both autistic and non-autistic clients. Although, with the exception of the C-SSRS, clinicians are equally likely to use screening tools with autistic and non-autistic clients, many clinicians in the current study do not use any validated measure to screen for suicide. This is concerning given two related findings that influenced the Joint Commissions' (2019) decision to mandate/recommend (depending on the setting) suicide screening: (1) Clinicians who use standardized screening measures are more likely to accurately detect clients' suicidal thoughts or behaviors than those who do not (e.g., Bongiovi-Garcia et al. 2009; Brown et al. 2015; Malone et al. 1995); and (2) Nearly 50% of individuals who die by suicide visit a healthcare provider in the four weeks preceding their death and 83% in the year before their death, demonstrating opportunities for identification of risk and subsequent intervention (Ahmedani et al. 2014). Although certain screening tools (e.g., C-SSRS) can also aid in the prediction of future suicidal behavior and deaths (e.g., Madan et al. 2016; Simon et al. 2016), other screening tools are poor predictors of such adverse events (e.g., de Beurs et al. 2016; Cassidy et al. 2018). Research suggests that *validated* screening tools can play an important role in identifying individuals at risk for suicide, but should not be used in isolation to determine treatment decisions and follow-up care (e.g., Quinlivan et al. 2017, 2019). Similarly, although the development and validation of suicide screening tools for autistic individuals is an important first step to reliable identification of suicidal thoughts and behavior in this population, clinicians should avoid over-relying on these tools for treatment planning.

Clinicians' attitudes towards screening did not differ for autistic and non-autistic clients. However, consistent with clinicians' relatively low use of screening measures, attitudes towards screening were only moderately positive on average across groups (mean scores were less than 7 on a scale of 0 = "bad" to 10 = "good"). Given that clinician attitudes towards a given behavior predict intentions to implement that behavior (Fishbein and Ajzen 2010), future research should develop and test implementation strategies that target clinicians' attitudes towards screening.

This study has limitations. In an effort to minimize participant burden, some constructs were measured with a single item (i.e., attitudes, self-efficacy). In addition, data were collected via self-report and it is not possible to verify the accuracy of clinicians' report of screening and intervention practices or the prevalence of clients at elevated risk for suicide. Finally, although participants reported level of education and degree type, they were not asked to identify their job titles. Therefore, we are unable to conduct more fine-grained analyses to examine differences between various types of clinicians.

Understanding current screening and intervention practices for autistic adolescents and adults across diverse settings in which autistic individuals receive care is an important first step in reducing the rising, concerning rate of suicide in this population. Next steps include adapting detection and intervention tools for autistic clients, as well as developing strategies to maximize the likelihood that these practices are implemented in real-world settings.

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**Author Contributions** SJH, BMM, and DSM conceived of the study. SRC, SJH, BMM, and DSM developed and reviewed the survey questions. SRC participated in the coordination of the study and data collection. SJH performed the statistical analyses. SJH and BMM drafted the manuscript. All authors read and revised earlier drafts of the manuscript. All authors approved the manuscript for publication.

## Compliance with Ethical Standards

**Ethical Approval** All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee [redacted to maintain masked review] and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards."

## Appendix

### Survey of Clinician Suicide Risk Management in Clients with Autism For the questions below, please think about your clients *without* autism.

1. What percent of your clients **without** autism experience suicidal thoughts or behaviors?

0%	1-10%	11-20%	21-40%	41-50%	51-100%	Not applicable; I don't have any clients without autism
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2. Do you use a standardized measure to screen for suicide risk with your clients **without** autism?

Yes	No	Not applicable; I don't screen for suicide risk
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a. If yes, please indicate which measure(s) you use with your clients **without** autism:

Columbia Suicide Severity Rating Scale (C-SSRS)	Ask Screening Questions (ASQ)	Beck Depression Inventory (BDI)	Patient Health Questionnaire (PHQ-9)	Self-Injurious Thoughts and Behavior Interview (SIT-B)	Other suicide screening measure (write in)
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b. If no, please describe your suicide risk screening process for your clients **without** autism:

3. Think about your clients **without** autism. If you were to screen for suicide risk with these clients, it would be...: (Select a number from 0-10 that reflects your opinion.)

<b>Bad</b>										<b>Good</b>
0	1	2	3	4	5	6	7	8	9	10

4. How much would each of the following groups **disapprove or approve** if you screen for suicide risk with your clients **without** autism? (For *each* row, select a number.)

	Strongly disapprove	Disapprove	Neither disapprove nor approve	Approve	Strongly approve
Other clinicians like me would...	1	2	3	4	5
My supervisor would...	1	2	3	4	5
My clients would...	1	2	3	4	5

5. If you wanted to screen for suicide risk with your clients **without autism**, how sure are you that you can do that? (*Select one number below.*)

1 Very sure I cannot	2 Sure I cannot	3 Uncertain	4 Sure I can	5 Very sure I can
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6. The **Safety Planning Intervention** (Stanley and Brown, 2012) is a brief intervention designed to lower the short-term risk of suicide that includes working collaboratively with clients to identify: (1) warning signs that signal the need to use the safety plan; (2) internal coping that can be employed by individuals on their own; (3) social supports and social settings that can serve as sources of distraction; (4) friends and family members with whom an individual can discuss their suicidal thoughts and urges; (5) professionals to contact during emergencies; and (6) ways to reduce access to lethal means.

Which of the following choices describes your experience with the Safety Planning Intervention as described above (please check all that apply):

Have not heard of it	Heard of it	Received training in the intervention	Use in my practice with individuals with autism	Use in my practice with individuals without autism
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7. Using the Safety Planning Intervention as a suicide prevention strategy with individuals **without** autism would be acceptable to me (*Select a number from 0-10 that reflects your opinion.*)

Strongly Disagree						Strongly agree					
0	1	2	3	4	5	6	7	8	9	10	

**For the questions below, please think about your clients with autism.**

8. What percent of your clients **with** autism experience suicidal thoughts or behaviors?

0%	1-10%	11-20%	21-40%	41-50%	51-100%	Not applicable; I don't have any clients with autism
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9. Do you use a standardized measure to screen for suicide risk with your clients **with** autism?

Yes	No	Not applicable; I don't screen for suicide risk
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- a. If yes, please indicate which measure(s) you use with your clients **with** autism:

Columbia Suicide Severity Rating Scale (C-SSRS)	Ask Screening Questions (ASQ)	Beck Depression Inventory (BDI)	Patient Health Questionnaire (PHQ-9)	Self-Injurious Thoughts and Behavior Interview (SIT-B)	Other suicide measure (write in)
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- b. If no, please describe your suicide risk screening process for your clients **with** autism:



10. Think about your clients **with** autism. If you were to screen for suicide risk with these clients, it would be...: (Select a number from 0-10 that reflects your opinion.)

<b>Bad</b>										<b>Good</b>
0	1	2	3	4	5	6	7	8	9	10

11. How much would each of the following groups **disapprove or approve** if you screen for suicide risk with your clients **with** autism? (For each row, select a number.)

	Strongly disapprove	Disapprove	Neither disapprove nor approve	Approve	Strongly approve	
Other clinicians like me would...	1	2	3	4	5	
My supervisor would...	1	2	3	4	5	
My clients with autism would...	1	2	3	4	5	NA- I don't see adults with autism

12. If you wanted to screen for suicide risk with your clients **with autism**, how sure are you that you can do that? (Select one number below.)

1 Very sure I cannot	2 Sure I cannot	3 Uncertain	4 Sure I can	5 Very sure I can
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13. Using the Safety Planning Intervention as a suicide prevention strategy with individuals **with** autism would be acceptable to me (Select a number from 0-10 that reflects your opinion.)

<b>Strongly Disagree</b>										<b>Strongly agree</b>
0	1	2	3	4	5	6	7	8	9	10

**Please answer the following questions about yourself and your clinical practice.**

14. Where do you work?

Community mental health center	Developmental pediatric clinic	Autism-specific clinic	School-based setting	Hospital unit	Other: _____
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15. What percent of your clients have autism?

<b>0%</b>	<b>1-10%</b>	<b>11-20%</b>	<b>21-40%</b>	<b>41-50%</b>	<b>51-100%</b>
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16. What is the age range of your clients?
17. What is the average age of your clients?
18. What are your clients' typical presenting problems? Please check all that apply:
- ADHD
  - Anxiety disorders
  - Autism spectrum disorder
  - Challenging behaviors (e.g., aggression, irritability)
  - Intellectual disabilities
  - Mood disorders
  - Psychotic disorders
  - Substance use
  - Trauma-related problems
  - Other (please specify: \_\_\_\_\_)
19. What is your gender?
- Female
  - Male
  - Other (please specify: \_\_\_\_\_)
20. How old are you (in years?) \_\_\_\_\_
21. Are you Hispanic/Latino(a)?
- Yes
  - No
22. Which of the following do you consider your race/ethnicity? (Please check one or more)
- White
  - Black/African American
  - American Indian
  - Alaska Native
  - Middle Eastern
  - Asian
  - Native Hawaiian or Other Pacific Islander
  - Other (please specify: \_\_\_\_\_)
23. Please select your highest level of education.
- Some high school
  - High school
  - Some college
  - Vocational/Associate's degree
  - College
  - Graduate/Professional (please specify degree type and discipline: \_\_\_\_\_)
  - Other (please specify: \_\_\_\_\_)

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