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BRIEF COMMUNICATION

Over-Represented and Under-Served: Autistic Children and Young People Seeking Help for Suicidal Crisis in a UK Emergency Department

Emma Ashworth[1] · Pooja Saini[1] · Claire Hanlon[1] · Anna Hunt[1] · Molly McCarthy[1] · Sio Wynne[1] · Vivienne Crosbie[2] · Lucy Bray[3] · David Moore[1] · Abigail Knight[1] · Georgia Pavlopoulou[4,5]

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Abstract

Purpose Hospital Emergency Departments are increasingly playing a role in the care of young people experiencing suicidal crisis. Autistic young people, who already experience elevated rates of suicidal thoughts and death by suicide, may face particular difficulties in such environments.

Methods This retrospective medical records review explored patterns of Emergency Department attendance for suicidal crisis among young people (aged 8–16 years) attending a UK paediatric hospital between 2019 and 2021. Anonymised clinical records from 338 young people were analysed using descriptive and exploratory statistics.

Results 35.8% of attendees were autistic and 62.0% of those were female. Autistic young people were attending at significantly younger ages than non-autistic young people, and were significantly more likely to be known to mental health services and to have attended the Emergency Department previously for suicide ideation.

Conclusion Findings indicate that autistic young people, and in particular autistic females, were over-represented in crisis presentations, despite previous attempts to seek help. Further research is needed to understand what could help prevent autistic young people from reaching crisis, and what support may be beneficial in the Emergency Department to de-escalate crises, improve wellbeing, and prevent re-attendance.

Keywords Autism · Suicide ideation · Emergency departments · Suicidal crisis · Children and young people

Hospital Emergency Departments (EDs) operate within a biomedical model of healthcare, predominantly designed to treat acute physical illness or trauma. Despite this, they are increasingly playing a critical role in the care of young people (YP) experiencing mental health crises, including suicide ideation and attempts (Pagliaccio et al., 2025; Virk et al., 2022). However, given EDs are often fast, noisy, and procedural, they are unlikely to be calming during a crisis, and may exacerbate distress (Niro et al., 2025).

Autistic YP experience elevated rates of suicidal thoughts and death by suicide (Huntjens et al., 2024). Emerging evidence suggests they are disproportionately represented in ED presentations for suicidal crisis and may experience repeated attendances and unmet support needs when seeking help (Blanchard et al., 2021, 2025). Given EDs can be associated with sensory overload and are also unpredictable and socially demanding, this may further exacerbate distress for autistic YP (Litwin & Sellen, 2023; Niro et al., 2025).

Despite emerging evidence regarding suicidality among autistic YP, less is known about patterns of ED presentation for suicidal crisis within paediatric UK settings, including demographic characteristics, prior service involvement, and attendance rates of those seeking help. Greater understanding of presentation patterns may help identify opportunities for earlier intervention and the delivery of more accessible and effective crisis care. The present study therefore aimed

✉ Emma Ashworth
e.l.ashworth@ljmu.ac.uk

Georgia Pavlopoulou
georgia.pavlopoulou@ucl.ac.uk

1 School of Psychology, Liverpool John Moores University, Liverpool L3 3AF, UK

2 Alder Hey Children's NHS Foundation Trust, Liverpool, UK

3 Faculty of Health and Social Care, Edge Hill University, Ormskirk, UK

4 Department of Clinical, Educational and Health Psychology, University College London, London, UK

5 Anna Freud Centre, London, UK

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to explore and compare patterns of ED attendance for suicidal crisis among autistic and non-autistic YP attending a UK paediatric hospital. Specifically, the study aimed to examine:

1. Whether autistic YP were more prevalent than non-autistic YP among ED presentations for suicidal crisis.
2. Whether demographic (age, sex) and clinical characteristics (mental health diagnoses, and mental health service involvement) differed between autistic and non-autistic attendees seeking help for suicidal crisis.
3. Whether autistic YP were more likely than non-autistic YP to experience repeated ED attendance for suicidal crisis.

Methods

Design and Setting

This retrospective medical records review sought to explore patterns of ED attendance when seeking help for suicidal crisis (defined as ideation with/without self-harm, but without a suicide attempt) at one UK paediatric hospital over a three-year period (March 2019 - March 2022). The hospital is one of Europe's largest children's hospitals, serving a broad and diverse community. As a tertiary paediatric service, the hospital receives referrals from both local urban and wider regional catchment areas. The dedicated ED provides emergency physical healthcare alongside assessment and management of children and YP presenting in mental health crisis. The hospital also has its own Child and Adolescent Mental Health Services (CAMHS), a multidisciplinary team who provide support to YP experiencing moderate to severe mental health difficulties in both in- and out-patient clinics, as well as a dedicated CAMHS crisis team who provide mental health liaison and assessments in the ED when YP present with suicide ideation.

Data Extraction and Analysis

Access to the anonymised clinical records data was approved by the hospital's research department as part of a clinical audit. Clinical records at the hospital were reviewed between March 2019 and March 2022. Inclusion criteria included any patients aged 16 or younger who presented to the ED in suicide crisis during the study period. Anonymised data on YP who visited the hospital and whose primary diagnosis was recorded as 'suicide ideation' were extracted and provided to the researchers by the hospital data team. An electronic inspection of the clinical notes was then performed by the researchers through the Meditech system.

Variables extracted from clinical notes included age, biological sex, ethnicity, a recorded autism diagnosis (including formal clinical diagnosis, on the diagnostic pathway, or suspected/self-identified autistic), recorded mental health conditions, a record of previous or current engagement with CAMHS, and where the YP was recorded as being referred/discharged to after ED attendance. These data were routinely collected either from the family using a standard pro forma completed by the clinician when triaging the patient, or they were already available on the hospital system if the patient had previously been reviewed by and/or was currently known to CAMHS. Number of previous ED attendances of suicidal crisis were also calculated by summing the total number of recorded visits during the three-year period (for multiple attendances, analyses were conducted based on the first visit).

Unadjusted exploratory analyses were conducted, with descriptive statistics used to identify the characteristics of the sample, and t-tests and chi-square tests used to establish statistically significant associations/differences. Given the data collection period included the first year of the COVID-19 pandemic (2020), a chi-square test was also conducted to establish whether there were any differences in patterns before, during, or after the pandemic. While the researchers had access to all records, the dataset only captured entries made in clinical records; unrecorded clinical activity or missing information from ED documents was therefore unavailable. For the purposes of this study, only the presence of each factor within each person's clinical records was used for the analysis.

Key Findings

Data were extracted and analysed for 338 YP, aged 8–16 years, across 472 visits (see Table 1).

Over-Representation of Autistic YP

Autistic YP (35.8%; $n = 121/338$) were disproportionately represented in the sample of individuals who attended the ED for suicidal crisis (based on a population prevalence of 1–2% in the UK (Roman-Urrestarazu et al., 2021). 17.8% ($n = 60$) had a formal autism diagnosis, and a further 18.0% ($n = 61$) were recorded as having 'autistic traits', awaiting a diagnosis, or self-diagnosed/identified. There was no significant difference in prevalence rates by year of attendance. Given systemic and socio-demographic barriers to autism assessments in the UK, including the long waiting times via the National Health Service (NHS), regional disparities

Table 1 Individual characteristics of patients presenting in suicidal crisis

Demographic	Overall Sample	Autistic Sample	Non-Autistic Sample
	Mean (range)	Mean (range)	Mean (range)
Age	13.50 (8–16)	13.24 (8–16)	13.65 (10–16)
	N (%)	N (%)	N (%)
Sex			
Male	106 (31.4%)	46 (38.0%)	60 (27.6%)
Female	232 (68.6%)	75 (62.0%)	157 (72.4%)
Autism Diagnosis			
Autistic – formal diagnosis	60 (17.8%)	–	–
Autistic traits, awaiting diagnosis, self-diagnosed/ identified	61 (18.0%)	–	–
None	217 (64.2%)	–	–
Previous mental health difficulties	176 (52.1%)	77 (63.6%)	99 (45.6%)
Previously known to CAMHS	195 (57.7%)	90 (74.4%)	105 (48.8%)
Currently under CAMHS	73 (21.6%)	39 (32.2%)	34 (15.8%)

in assessment services, financial implications of private assessments, under/late diagnosis rates in some groups (e.g., autistic females), biases in diagnosis or diagnostic criteria, and the rising recognition of self-diagnosis/identity in the autism community, the decision was made to group all 'suspected' and formally diagnosed autistic YP together for further analyses in order to ensure an equitable and inclusive approach in line with the Neurodiversity paradigm (Aylward et al., 2021; Friedman et al., 2024; Howes et al., 2021; Lockwood Estrin et al., 2021; Parr et al., 2024; Wigham et al., 2022; Woolhouse & Nicholson, 2026).

Earlier Onset of Suicidal Crisis

Autistic YP presented in suicidal crisis at a significantly younger mean age than their non-autistic peers (youngest presentations aged 8 vs. 10 years respectively), $t(336) = 2.250$, $p = .013$. There was no significant difference in mean age presentation by year of attendance. This aligns with research indicating that suicidality may emerge earlier in autistic populations (Schindel et al., 2024).

Sex Differences

A disproportionately high number of autistic females attended the ED for suicidal crisis (62.0%; $n = 75$). There were no significant differences by year of attendance. Given that males are more likely to be diagnosed autistic than females, at a 4:1 ratio (Cruz et al., 2025), it could be hypothesised that autistic females are experiencing greater distress. Indeed, autistic males were more likely than females to have a formal autism diagnosis in the current dataset (60.9% males vs. 42.7% females), $X^2(2, N = 338) = 8.015$, $p = .018$ (OR = 2.092; CI = 0.989–4.425). This mirrors growing recognition that autistic females are under-identified in childhood and may "mask" their traits, leading to missed diagnosis, heightened internalising symptoms, and increased risk of anxiety, depression, and suicidality (Milner et al., 2024). This is supported by our dataset, whereby autistic females (40.0%; $n = 30$) were more likely to currently be known to CAMHS for diagnosed mental health difficulties than autistic males (19.5%; $n = 9$), $X^2(1, N = 121) = 5.451$, $p = .020$ (OR = 2.741; CI = 1.157–6.494). Findings thus highlight the need for earlier recognition and tailored support for autistic females. With the growing recognition of high levels of gender diversity in autistic populations (Corbett et al., 2023), it would also be beneficial to further explore this intersection.

Service Involvement and Engagement

Autistic attendees were significantly more likely to have a pre-existing diagnosed mental health condition than non-autistic attendees, $X^2(1, N = 335) = 9.358$, $p = .002$ (OR = 2.033; CI = 1.286–3.212). Almost two-thirds of autistic attendees had a diagnosed mental health condition (63.6%; $n = 77$), compared to just under one-half of non-autistic attendees (46.3%; $n = 99$). Fewer autistic YP attending the ED for suicidal crisis had a diagnosed mental health condition in the year after the COVID-19 pandemic (44.1%; $n = 15$), compared to before (72.1%; $n = 31$; OR = 0.923; CI = 0.364–2.328) or during (70.5%; $n = 31$; OR = 0.306; CI = 0.118–0.790), $X^2(2, N = 121) = 7.811$, $p = .020$. This aligns with national data indicating high rates of co-occurring mental health conditions in the autistic population (Lai et al., 2019).

Furthermore, autistic attendees were significantly more likely to have previously been seen by CAMHS for mental health difficulties than non-autistic attendees, $X^2(1, N = 336) = 20.742$, $p < .001$ (OR = 3.040; CI = 1.866–4.950), with approximately three-quarters of autistic attendees (74.4%; $n = 90$) previously known to CAMHS, compared to half of non-autistic attendees (48.8%; $n = 105$). Autistic attendees were also significantly more likely to be currently 'under' CAMHS (i.e., in the process of receiving support or on a waiting list) when they presented at the ED (32.2%; $n = 39$), compared to non-autistic attendees (15.8%; $n = 34$), $X^2(1, N = 336) = 12.271$, $p < .001$ (OR = 2.532; CI = 1.493–4.292). Autistic attendees were less likely to be previously known to CAMHS in the year

after the COVID-19 pandemic (52.9%; $n=18$), compared to before (81.4%; $n=35$; OR = 0.257; CI = 0.093–0.714) or during (84.1%; $n=37$; OR = 0.213; CI = 0.074–0.609), $X^2(1,N=121)=11.489$, $p=.003$. There were no differences in autistic YP being currently 'under' CAMHS by year of attendance.

Additionally, autistic individuals were significantly more likely to have repeated (>1) attendances at the ED for suicidal crisis over the three-year period (31.4%; $n=38$) compared to non-autistic individuals (17.5%; $n=38$), $X^2(1,N=338)=8.603$, $p=.003$ (OR = 2.155; CI = 1.282–3.623). However, there was no significant difference in referral pathways between autistic and non-autistic individuals after ED attendance, suggesting they were equally likely to be admitted as an inpatient, receive outpatient care, be referred to CAMHS/other specialist services, or be discharged.

Discussion

Autistic YP were over-represented in crisis presentations, were attending at younger ages than non-autistic peers, and were more likely to be female. This study also highlights a paradox: autistic YP were more likely to be known to mental health services and to have sought help at the ED previously, but were more likely than non-autistic YP to be presenting (and re-attending) at the ED in suicidal crisis. Collectively, the data demonstrate that these YP were not invisible to services, highlighting a potential systemic gap between recognition and effective early and ongoing intervention, and positioning EDs as the "safety net" for repeated crises, rather than as part of an integrated continuum of care. This ultimately may indicate they are not receiving the help they need within the community, earlier in the clinical care pathway, or once they reach the ED. Below, we outline potential implications for each stage of the clinical pathway, identifying strategies that may improve the support autistic YP are offered, helping to prevent and effectively de-escalate crisis.

Before Crisis: Effective Early Intervention, Prevention, and Community Support

The paradox we identify regarding high rates of ED attendance, despite previous interactions with CAMHS and diagnosed mental health conditions, reflects broader systemic pressures in the UK NHS. CAMHS waiting lists in the UK are long, with YP often declined appointments due to both high levels of demand and stipulated high thresholds of need. Autistic YP face further challenges accessing CAMHS for mental health difficulties due to diagnostic overshadowing (particularly for autistic females), siloed services, and offers of inappropriate therapies preventing engagement (Ashworth, Bray, Hanlon, Stanway et al., 2025b). This results in YP's mental health worsening while waiting for support (Dvorsky et al., 2014) and highlights the need to improve the availability and accessibility of the service, with reasonable adjustments and appropriately adapted therapies.

Given the high rates of suicidal crisis in the autistic population, and that many of these crises are preventable, effective early intervention work may be beneficial in the community and within schools, where autistic YP encounter many difficulties (Ashworth et al. 2025a, b; Fisher et al. 2025). This is particularly important in light of the younger relative age of autistic YP presenting in crisis in the current sample, underscoring the need for further research to understand the support needs and effective prevention strategies in early education. Indeed, the provision of reasonable adjustments, a safe and secure neuroaffirmative environment, and trauma-informed support could all reduce the likelihood of mental health difficulties from arising and escalating (Mcgreevy et al., 2023). However, it is important to note that many of the YP most in need of support are currently not able to attend school (Preece & Howley, 2018), and so tailored provision is also required beyond traditional educational settings.

During Crisis: Developing Neuroaffirmative EDs

Higher rates of re-attendance, and no differentiation in referral pathways, suggests that autistic YP were not getting the individualised support they needed in the ED. Several factors relating to the physical ED environment, staff communication, and a lack of community-based alternatives have previously been raised as issues to address in order to provide more effective ED support for autistic YP, and ultimately reduce re-attendance. For instance, existing evidence suggests that ED care may need to adopt an experience-sensitive approach that recognises how sensory, communicative, and relational factors shape distress and help-seeking (Mcgreevy et al., 2023; Pavlopoulou et al., 2025). Similarly, the sensory environment of the ED can intensify overwhelm, hindering assessment and increasing the likelihood of leaving without being seen. Simple environmental adjustments, such as access to low-stimulus spaces (Bray et al., 2025), or temporary adaptations, such as mobile multisensory resources, ear defenders, or pager systems that allow YP to leave the waiting area, may meaningfully improve tolerability and engagement (WUTH NHS Trust, 2026).

Communication differences and diagnostic overshadowing may further complicate ED presentations for autistic YP (Ashworth, Bray, Hanlon, Stanway et al., 2025b). Distress may be expressed in non-verbal ways, increasing the

risk that suicidal intent is misinterpreted or missed in time-pressured environments (Cervantes et al., 2023; Donaghy et al., 2023; Johnson et al., 2023). Communication differences with staff can also lead YP to mask, shut down, or withhold disclosures due to reduced trust and perceived safety (Cervantes et al., 2025). Ultimately, this may mean that autistic YP do not get the help they need, resulting in high rates of re-attendance. To address this, there are emerging examples of autism-specific tools implemented in NHS services, such as 'communication passports' (Ellis et al., 2023) and 'reasonable adjustment flags'(NHS Digital, 2026) or checklists (CWP NHS Trust, 2022), to support shared understanding across clinical and non-clinical staff (Ellis et al., 2023; McCarthy et al., 2024).

To ensure referral pathways are tailored, appropriate, and effective, an experience-sensitive response could also include every ED having rapid access to liaison psychiatry or CAMHS clinicians specifically trained in autism. This would ensure that discharge decisions and follow-up care consider the neurodevelopmental context and are collaborative, made *with* rather than *on* the autistic person. For instance, a recent trial has examined the feasibility of autism-adapted safety plans (Rodgers et al., 2024); these could be co-developed with YP and their parents/carers, outlining coping strategies, preferred communication styles, when and where to get help, and YP's rights if ED attendance becomes necessary (e.g., reasonable adjustments and how to request these).

Finally, the development and promotion of neuroaffirmative crisis alternatives in the community (e.g., drop-in hubs, crisis cafés, and home-visiting crisis teams) could offer more appropriate pathways for support. Indeed, parents often describe how they feel there is no alternative but to attend the ED when their YP are experiencing crisis (Ashworth, Bray, Hanlon, Pavlopoulou et al., 2025a). Providing predictable, quieter, and relationally safe support would reduce the need for ED care, provide an appropriate referral pathway, and align with the NHS Long Term Plan (NHS England, 2019).

Systemic Change: Policy Implications and Future Research

In order to implement strategies that reduce rates of suicidal crisis (particularly among younger and female autistic YP), provide effective care, and prevent re-attendance in the ED, services will need to work collaboratively with autistic YP to ensure they feel safe and supported when seeking help. These services must then be provided with adequate Government funding and resources to ensure delivery.

Furthermore, a lack of staff training means that autism remains poorly understood across education and healthcare settings (Brookman-Frazee et al., 2012; Niro et al., 2025). Autism-specific training would ensure professionals have a clear understanding of what autism is (and what it is not), how mental health difficulties and distress might present, how communication styles may differ, and reasonable adjustments that could be implemented. This is particularly pertinent given the NHS Long Term Plan (NHS England, 2019), which includes improving understanding and meeting the needs of autistic people.

Finally, while our findings provide valuable insights, our study represents only a small first step. There is a need for further research, including multi-site, longitudinal, and qualitative approaches, to gain a more nuanced understanding of what needs to change in both early intervention strategies and in ED settings. Further work is also needed to gain a greater understanding of some of the key findings, such as younger relative age and the high prevalence of autistic females in the cohort, and to further explore the role of potentially important contributing variables that were not available here (e.g., gender, communication preferences, intellectual disability).

Limitations

Several limitations should be considered when interpreting these findings. First, this was a retrospective single-site study in the UK with a public paediatric NHS hospital; thus, this limits generalisability to other ED settings and healthcare systems internationally. Second, the study relied on routinely collected clinical records, which may have contained inconsistencies, under-recording, or incomplete documentation. Third, some YP were categorised as having "autistic traits" or awaiting assessment, reflecting the challenges of accurately capturing neurodevelopmental status within clinical records. Relatedly, while we made the decision to group all YP diagnosed as or "suspected" to be autistic together in order to reflect current issues and trends in the autism community, it is possible that those without a formal diagnosis may have experienced differences when attempting to access services or EDs previously, which may influence subsequent mental health outcomes. Finally, the analyses were unadjusted, and the study design does not allow conclusions regarding causality or the mechanisms underlying repeated crisis presentations. Further analyses would also benefit from multivariable modelling approaches to better disentangle the contributions of autism, age, co-occurring mental health conditions, sex and gender, and service involvement to crisis presentations.

Conclusion

Autistic YP, and autistic females in particular, were over-represented in crisis presentations, were more likely to re-attend, and were attending at younger ages than non-autistic peers, despite them often having existing involvement with CAMHS. This provides British evidence for a repeated global trend and has implications for policy and practice within EDs. The high rates of ED attendance among autistic YP also highlights the importance of and need for accessible and neuroaffirmative early intervention and community services, in order to prevent autistic YP reaching the point of crisis.

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Data Availability The dataset analyzed during the current study is not publicly available as the data are sensitive and confidential, but is available from the corresponding author on request.

Declarations

Conflict of interest The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Ethical Approval Ethical approval and patient consent were not required for this study, as data were retrospectively obtained and anonymised prior to analysis.

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