The SAFER Autism Checklist: Can your client with autism and trauma answer yes?

This is a checklist under the umbrella of the SAFE-T Model for safer treatment of behavior after trauma, by Dr. Camille Kolu Ph.D., BCBA-D.

Systems support, supervision and safety are present.

- ❑ My team has appropriate professionals on it who share values. They collaborate in robust ways and communicate effectively. I am important on my team and my opinions are taken into account. My team obtains my assent as we work together on things important to me.
- ❑ If my team has a supervisor or administrator, that person champions my needs and provides adequate training and support for the team members who support me. They think a few years ahead and build partnerships and collaborations and obtain mentorship and education to insure we are always moving toward our values.
- ❑ If I need special trauma related (or mental health, or medical, or any other kind of) support in addition to behavior analysis, I have it.
- ❑ I have at least one safe person and place. I have skills to request things that I need and people understand. I don't have to ask a certain way to get my basic needs met or to get out of a situation that is aversive or unsafe for me.

Assessment of risks takes place regularly.

- ❑ People around me look at me as a whole and individual person before recommending programs. My clinicians follow ethical guidance to do a risk versus benefit analysis to make sure a program is right for me and the benefits outweigh the risks. Even if the procedure is "best practice" for someone else, my team still does a risk analysis to make sure it's right for ME.
- ❑ If I have been through trauma, my team looks at the specific risks conferred by those situations and plan accordingly. My team puts risk mitigation plans into place
- ❑ I provide input into my assessments, including assessments of risks I might face because of my needs, behavior, and history.
- ❑ There are risks I face more than other people may because I have autism or that are related to experiences I've had as an autistic person. My team knows what these are and are curious about them. They communicate about them with other people if needed. They are documented in my assessments, specific to how they affect me and my needs.

Functional behavior approach takes my history and alternatives into account

- ❑ My behavior is viewed in the context of its history and current environment; the alternatives available to me (and to my caregivers), the consequences for them and contributions to them; and our historical suffering or challenges we have faced as a community, a family, or a people – rather than in terms of only my behavior's immediate antecedents and consequences.
- ❑ My team takes care to assess and document how trauma, or aversive childhood and/or conditioning experiences, contribute(d) to challenges including behaviors targeted in my plans, and communicates about this with others.
- ❑ Consistent with best practices, but also individualized practices, my team uses functional assessment (FBA) of behaviors. They take history into account. If there are medical components to my behavior these are well documented (even if my caregivers can't follow up right away, my team all works together to insure it's not forgotten). My medical professionals understand the links between trauma, medical outcomes and possibilities, and how these can show up in my behavior or additional medical needs.
- ❑ My team documents both my preferences AND what I find aversive (and why), in our documentation. My strengths are well-assessed and documented.
- ❑ My team gets my input and informed consent before and during my assessments and they review the results with me.

Environmental support is present for me and my team members.

- ❑ If needed I have a trauma-informed plan. My team documents which procedures may be (even temporarily) counter-indicated based on my history and needs. My team minimizes aversive control and coercion at all times. There are "plans to restore" in the event that I ever need a temporary restriction.
- ❑ My team and I agree I am doing my best and that sometimes my best is different than it is at a different time. I have many alternatives available to switch to if something isn't working.
- ❑ I have things I enjoy doing and have free access to, and I'm working on becoming fluent in doing the things that will make a difference for me many years in the future. Meeting my basic needs is never contingent on me asking a certain way.
- ❑ I have the support, structure, or other things I need to get adequate sleep, nutrition, and exercise. No matter what my "functioning" level, I am being supported to gain skills in coping with stress, enjoying leisure activities, and developing or enjoying relationships with (a) safe person(s). If even one of these is disrupted my team notices, and we work on getting me back on track and understand the impact this could have if not corrected.
- ❑ My team members may have been through trauma too. It's possible I have experienced challenges related to the trauma a caregiver experienced. These are all explored and I'm not the only member of my team who is supported with a trauma-healing approach; we all are, from my caregivers and staff to my teachers.

Review of these things takes place periodically (not implemented once then ignored)

- ❑ My team updates all my assessments when appropriate, when things change, or when I move environments, and I am not forced to work on old goals "just because" they were important in a different environment. If there are new risks they are documented, and my assessments and plans are updated. This might happen I moved or obtained a new team member or gained a new skill or experienced an aversive situation.
- ❑ When my behavior changes, my team members agree to look first at whether I am suddenly in an unsafe environment or exposed to someone who is unsafe, or if I am hurting because of something hidden that I may be struggling to communicate. Medical concerns are ruled out (and when present, my team collaborates to help me solve them).

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Review of the SAFE-T Model: Safer and ethical treatment of behavior after trauma

The SAFE-T model is a way of supporting supervisors and teams working with trauma informed behavior analytic interventions, and a model for supporting clients and families who may have behavior related needs after trauma related events.

In the "S" phase, we learn how to provide proactive supervision and support to the team. For example, supervisors working on trauma informed teams will have greater responsibilities for establishing system support, setting up appropriate documentation, and training personnel in order to do no harm and practice within our competence.

In phase "A", we learn how to do more robust assessment to protect clients and their families and communities (including teams, agencies and educators). In particular, the model focuses on the assessment of risks, helping teams to follow ethical guidelines to assess the potential outcomes, risks and benefits of treatment decisions from taking on a case to making treatment recommendations.

The SAFE-T model uses "F" to remind us to expand the functional behavior assessment portion of our behavior analytic services as appropriate for clients who have been through trauma or serious adverse childhood or other experiences. Instead of looking primarily at the immediate functions of behavior, we insure we examine historical variables that could have contributed to the current presentation of needs.

In phase "E", we insure that we evaluate needs before we get to treatment. In doing this we look at the behavioral environment, and return to those needs that are not being met. We address those through partnerships, our own work, or referrals to make it safe to proceed. Often, a family or client who has been through trauma may need other things before we recommend behavioral treatment; making sure the client is physically safe or fed may come before attempting to reduce challenging behavior. At this step, we establish team communication in a collaborative way first, and insure the entire team is, or those appropriate are, aware of the risks on the case, the needs the client has, and the relationships of behaviors to the person's history.

In "T" we bring it all together, providing treatment that is informed by all the important aspects of the team and the person's goals and needs. There is triage and communication during treatment, and behavioral providers are encouraged to work in collaboration with the rest of the team, including caseworkers, therapists from different perspectives, and the client's family and educators. The treatment needs to include highly preventive environmental support, often what we call "antecedent interventions" in behavior analysis, instead of focusing on consequences.

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Checklist for teams: The following items suggest ways we can use the SAFE-T outline to provide safer autism support using ethics code items from the BACB Ethics Code (2022).

Systems support, supervision and safety are present.

____ 1.02 I practice within boundaries of competence
____ 1.02b I only teach with a new population, technique, behavior after appropriate study, training, supervision, and/or consultation
____ 1.03 I maintain competence through professional development
Also see related ethics items:
____ 3.03 We insure we have appropriate time and capacity for supervision on this important case
____ 2.10 We insure services are collaborative
____ 4.02 We provide supervision that is competent and effective (4.03)
____ 4.04 We make sure our supervision is accountable
____ 4.07 We address diversity through our supervision on this case
____ We make sure our clients and other people on the team know that behavior analysts collaborate to change behavior, not to eliminate "trauma symptoms". Behavior analysts treat behavior, not "trauma" (we practice in ways that are consistent with behavior analysis, and see section 1.0).
____ I will not accept clients (1.04c; 2.0) that are not appropriate or when there are not resources available to meet the kind (or extent) of needs the client has.

Toolbox ideas:

- Checklist for appropriate supervision and support
- Professional Support section of SAFE-T Assessment (A)

Assessment of risks takes place regularly.

____ 2.09 My client has a right to effective treatment and we have a responsibility to provide it. In order to insure treatment is effective, I know I must include assessment of trauma related variables in the assessment.
____ 2.13 I will do an assessment of the risks and needs for this case and be sure we are doing no harm.
____ 2.15 Part of my reason for including risk analyses is to later inform my selection of treatment options that reduce the likelihood of harm.
____ 2.03 I am ready to describe trauma related events in behavioral terms, refer to others, and obtain consultation when needed
____ 2.04 In advance, I am ready to carefully clarify the behavior analyst role for the team in advance and whenever asked. All behavior analysts on the case can do this.

Toolbox ideas:

- SAFE-T Assessment Section F: Documenting possible exposure to adverse experiences
- SAFE-T Assessment Section C: Documenting behavior concerns
- "Checklist to assess and document risks" helps to update your team's process
- Screening tool for trauma related behaviors and situations from SAFE-T Assessment
- Assessment of risks and needs from SAFE-T Assessment
- Risk versus benefit analysis template
- Risk mitigation template for communicating with team
- Risk versus Benefit Flowchart

Functional behavior approach takes history and alternatives into account

____ 2.12 Some experiences related to trauma can contribute a medical function to my client's behavior. (This might be the case if the client has early adverse experiences that change the brain; a diagnosis of fetal

alcohol syndrome or early drug exposure; abuse; or mental illness concerns and medical concerns after neglect and other trauma). So I will consider medical needs, document referrals, and follow up.
5th Edition Task List items:
____F-1: We review records and available data (e.g., educational, medical, historical) at the outset of the case (we examine, when necessary, variables related to operant-respondent interactions and those related to biological/ medical variables and their contributions.)

____F-1: If present, we document contributions of biological, medical or respondent conditioning events (these could also include developmental injuries, pharmacological problems, physical injuries or discomfort, disease or illness, genetic contributions, presence of toxins, or a combination of these)

____F-9: We interpret functional assessment data

Toolbox ideas:

- SAFE-T Assessment Section D: Documenting variables related to development
- Historical contributions of trauma are documented using a Trauma-informed FBA
- List of potentially counter-indicated procedures
- Checklist to assess and document momentary and historic environmental functions and determinants of behavior
- Medical Documentation Form FBA Supplement

Environment is assessed and supported

____ 2.19 we will address environmental conditions and other things that interfere with service delivery. Some of these might mean that we have to solve problems before we move on to behavioral treatment in order to help the client.
____ page 5 I will take a systematic approach to solving ethical dilemmas facing my client and the team. R for review of these items periodically and when appropriate
_____ 2.17 We will collect data and use data to make decisions (including about starting, continuing, modifying or terminating services)
_____ 2.18 I will continuously evaluate the interventions and stop using procedures that are counter-indicated for my client or that no longer have a favorable risk-benefit analysis

Toolbox ideas:

- SAFE-T Assessment section B: Documenting family complexity and related variables
- SAFE-T Assessment section E: Documenting interaction with caregivers
- IPASS tool (IPASS (Inventory of Potential Aversive Stimuli and Setting Events) can help document environmental contributions to trauma related behavior and concerns from a sensory environment perspective
- Buffer/ resilience scoring tool (can help assess whether client has tools that research shows can buffer against trauma effects)
- Basic Barriers Documentation Tool