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).
