EVALUATION OF THE SAFETY OF CHILDREN IN COEDUCATIONAL RESIDENTIAL SPECIAL SCHOOLS

A LITERATURE REVIEW

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Overview

In 2013 SAMS (Standards and Monitoring Services) was asked by the Ministry of Education in New Zealand to conduct a literature review on the safety of coeducational residential special schools. The focus of the literature review (Parker, 2013) was specifically on the safety of girls in such facilities, particularly with reference to sexual abuse, and the measures that would need to be put in place to limit or, preferably, eliminate such risks. The present work used the original review as a foundation document but added new literature since 2013.

The researchers employed search engines according to the following terms:

> Disability, Intellectual Disability, Learning Disability, Children, Youth, Adolescents, Special Schools, Residential care, Coeducation, Abuse, Sexual abuse, Staff, Peers

We also used citation indexes from key articles to track themes and related papers. Search results yielded papers that were relevant to residential care for young people, and more importantly, residential care associated with special schools. The reviewers also looked for papers that specifically referred to abuse and sexual abuse, and papers that considered measures to provide positive and supportive environments for youth. Many papers in the search categories provided papers on residential environments that ranged from custodial (due to court orders) to group home styles of support. Few papers focused primarily on residential special schools but all had common themes relating to either abuse or the elements of safe residential support of young people. This review is not completely exhaustive given the breadth of the literature available, but it draws on principle documents and research papers that provide an effective overview of the current literature.

What is clear from reviewing the literature on child/adolescent placement in residential care is a the need to provide a balanced perspective of both the worst case scenarios and the efforts to provide not only a safe and secure environment but one that results in the best outcomes. Much of the literature on abuse focuses on out-of-home care as a whole and not on the determinants that make up safe and secure environments. The results may therefore lead to a belief that all out-of-home, and specifically, residential placements, are bad[2]. Rather than 'throwing the baby out with the bathwater', this review will acknowledge the alarming prevalence of sexual abuse (or abuse of all types) both toward young people with disabilities generally (including people with learning disabilities and young people with emotional and conduct disorders) and those in residential care (as opposed to foster care). However, this work will be balanced against situations where abuse is not occurring and/or the elements that make it less likely for abuse to occur. Some of these papers involve observations from young people themselves into what works well, their families, support workers and professionals. The review will conclude with best practice guidelines for coeducational residential schools as expressed by reviewers in the United Kingdom but also those elements drawn from the international research.

[2] Euser, S., Alink, L.R.A., Tharner, A., van Ijzendoorn, M.H., and Bakermans-Kranenburg, M.J. (2013). The prevalence of child sexual abuse in out-of-home care: a comparison between abuse in residential and foster care. Child Maltreatment, 00(0), 1-11. (Published on-line) DOI: 10.1177/1077559513489848

Coeducational special residential schools

Most New Zealand children start school in a coeducational environment. The Ministry of Education website lists twenty-eight special day schools currently located in New Zealand to support students in Years 1-13 with high needs. All are coeducational[3]. Five residential special schools are listed for students who are hearing or vision impaired, have severe behaviour needs, or have educational, social and emotional needs together with a slow rate of learning[4]. Of these, Halswell Residential College, Salisbury School and Westbridge Residential School are designed for children with complex emotional and behavioural difficulties (with or without an intellectual impairment). All three are associated with the Intensive Wraparound Service (IWS). Currently Halswell Residential College and Salisbury School are single sex schools for boys and girls respectively.

The Intensive Wraparound service (IWS) in New Zealand mirrors initiatives, primarily in the United States, that aim to create a student-centred and family-centred partnership and coordination service between the individual, family/whanau, schools and government agencies using an ecological model. The New Zealand initiative is reported to be proportionately smaller than the USA "with a higher overall level of challenging needs and behaviours"[5]. Students admitted to Residential Special Schools with severe educational and behavioural needs in New Zealand have been supported by the IWS since 2014.

Most residential special schools for children in the UK with severe and multiple disabilities are managed by voluntary and independent agencies[6]. Single-sex special residential schools appear to be the exception rather than the norm. Of the 49 UK private and state residential schools for children aged 11+ with learning disabilities listed on a site for parents, 46 are coeducational. One is a single-sex school for boys, one for girls and one further school caters for both sexes separately[7]. Fifteen of the eighteen independent special schools in Scotland are coeducational[8].

[3] Accessed 21 July 2016 http://www.education.govt.nz/school/student-support/special-education/day-special-schools-for-students-with-high-needs.

[4] Accessed and last updated 21 July 2016, at http:// http://www.education.govt.nz/school/student-support/special-education/residential-special-schools

[5] Burgon, J.,Berg, M. and Herdina, N. (2016). *Patterns of Student Progress in the Intensive Wraparound Service*. NZCER IWS Evaluation, p 3.

[6] Paul, A., Cawson, P. and Paton, J. (2004). *Safeguarding Disabled Children in Residential Special Schools*, National Society for the Prevention of Cruelty to Children in association with the Council for Disabled Children, p 13

[7] *Which school for special needs?* Guide retrieved from: http://www.specialneedsguide.co.uk/

[8] *Scottish Council of Independent Schools, A guide to independent special schools in Scotland*. Retrieved from: http://www.scis.org.uk/assets/Uploads/Publications/AGuideToIndependentSpecialSchools1.pdf

Definitions of sexual abuse and disability

In the USA McEachern (2012) notes that child sexual abuse has been defined as:

> 'a type of maltreatment that refers to the involvement of the child in sexual activity to provide sexual gratification or financial benefit to the perpetrator, including contacts for sexual purposes, molestation, statutory rape, prostitution, pornography, exposure, incest, or other sexually exploitative activities[9]'.

In addition, each State has a definition for child abuse and neglect based on federal definitions cited in the Child Abuse Prevention and Treatment Act[10] and the Keeping Children and Families Safe Act[11] . The definition cited by McEachern (2012) will, however, be used for the purpose of this review.

'Intellectual disability' and 'intellectual impairment' are terms in common use in New Zealand, although the term 'learning disability', is favoured by *People First* NZ. British studies refer to learning disability and learning impairment and until recently 'mental retardation' was a term used in the USA. The term 'developmental disability' or 'delay' is also commonly used in the literature[12]. The terms intellectual disability/impairment and learning disability will be used interchangeably in this report because of the preponderance of articles from Great Britain using the term ' learning disability' and as an acknowledgement of the desired change in terminology by *People First NZ*. However, it should be noted that on occasion the research literature (outside of Great Britian) will frequently distinguish learning disability as distinct from intellectual disability[13].

[9] McEachern, A. G. (2012). Sexual abuse of individuals with disabilities: Prevention strategies for clinical practice. *Journal of Child Sexual Abuse, 21*(4), 386-398, p. 387, citing *US Department of Health & Human Services [USDHHS], Administration for Children*, Families Administration on Children, Youth and Families, Children's Bureau, 2010, p. 133.

[10] US Child Abuse and Protection Act, accessed at: CAPTA; 1996

[11] US Keeping Children and Families Safe Act, accessed at: Keeping Children and Families Safe Act of 2003

[12] However, developmental delay may often refer to reduced capacity caused by other conditions such as severe autism, sensory impairments, psychological or health conditions etc.

[13] In these cases individuals with an IQ below 70 to 75 and who present with poor overall adaptive behaviour scores are generally referred to as having an intellectual disability or impairment (American Association on Intellectual and developmental disabilities AAIDD; 2016 accessed: http://aaidd.org/about-aaidd#.V5fEwKJgIog, In contrast, 'Learning disabilities' will often be limited to all other students who have specific learning issue that "affect the acquisition, organization, retention, understanding or use of verbal or nonverbal information" (Learning disabilities association of Canada, official definition) 2016, accessed at: http://www.ldac-acta.ca/learn-more/ld-defined/official-definition-of-learning-disabilities.

Prevalence research into sexual abuse among young people with an intellectual disability

The prevalence and incidence of sexual abuse among young people with intellectual disabilities is difficult to establish, for a number of reasons:

- Official statistics on child sexual abuse do not distinguish the rate for people with disabilities from that of the general population.
- Many people with disability will not disclose abuse because they think they will not be believed[14].
- Some cannot disclose abuse because of the physical or emotional limitations imposed by their disability[15].
- Many studies report on incidence (the rate at which events occur in a population[16]) rather than prevalence (which gives a figure for a factor at a single point in time[17])[18] [19] [20] [21].
- Research studies on incidence and prevalence do not use comparable variables. For example they use different definitions of abuse, data collection methodology, populations studied, settings in which the abuse occurs, ages, and sample sizes.
- Some studies have small numbers of participants (less than 100)[22] and are of short duration, making it difficult to know how long the abuse has been occurring[23] [24]. Few longitudinal studies have been undertaken[25]

The more recent exceptions to many of the observations listed above is a series of papers in the Netherlands that focused on abuse toward children and youth in out-of-home care[26]. These papers first reviewed the reported prevalence of sexual abuse in residential and foster care settings by both

[14] Reiter, S., Bryen, D.N. and Shachar, I. (2007). Adolescents with disabilities as victims of abuse. *Journal of Intellectual Disability, 11*, 371-387.

[15] Bedard, C., Burke, L. and Ludwig S. (1998). Dealing with sexual abuse of adults with a developmental disability who also have impaired communication: Supportive procedures for detection, disclosure and follow-up. *The Canadian Journal of Human Sexuality*, *7*(1), 79–92.

[16] Last, J.M., Abramson, J.H. and Freidman, G.D. (2001). *A Dictionary of Epidemiology (4th ed)*. Oxford, Oxford University Press.

[17] Jekel, J.F., Katz, D.L., Elmore, G.J. and Wild, D. (2007). *Epidemiology, Biostatistics, and Preventive Medicine* (3rd edition), Philadelphia, WB Saunder.

[18] Beail, N. and Warden S. (1995). Sexual abuse of adults with learning disabilities. *Journal of Intellectual Disability Research*, *39*, 382–387

[19] Kvam, M.H. (2000). Is sexual abuse of children with disabilities disclosed? A retrospective analysis of child disability and the likelihood of sexual abuse among those attending Norwegian hospitals. *Child Abuse & Neglect*, *24*,1073–1084.

[20] McCormack, B, Kavanagh, D., Caffrey, S. and Power A. (2005). Investigating sexual abuse: Findings of a 15-year longitudinal study. *Journal of Applied Research in Intellectual Disabilities*, *18*, 217–227.

[21] Sequeira, H., Howlin, P. and Hollins S. (2003). Psychological disturbance associated with sexual abuse in people with learning disabilities: Case-control study. *The British Journal of Psychiatry*, *183,* 451–456.

[22] Balogh, R., Bretherton, K., Whibley, S., Berney, T., Graham, S., Richold, P., Worsley, C. and Firth, H. (2001). Sexual abuse in children and adolescents with intellectual disability, *Journal of Intellectual Disability Research, 45*(3), 194-201.

[23] McCormack, et al., (2005).

[24] McCreary, B.D. and Thompson, J. (1998). Psychiatric aspects of sexual abuse involving persons with developmental disabilities, *Canadian Journal of Psychiatry*, *44*, 350–355

[25] McCormack, et al., (2005).

[26] Euser et al (2013); Euser, S., Alink, L.R.A., Tharner, A., van Ijzendoorn, M.H., and Bakermans-Kranenburg, M.J. (2016). The prevalence of child sexual abuse in out-of-home care: Increased risk for children with mild intellectual disability. *Journal of Applied Research in Intellectual Disability, 29*, 83-92.

sentinels (staff and professionals who provide direct support) and self-reports over a calendar year in 2010. Sexual abuse was divided into situations involving sexual abuse (1) with penetration, (2) with genital contact (without penetration), (3) physical contact (without conditions 1 & 2), (4) without physical contact and (5) other unwanted contact with sexual content. The original sample involved 329 adolescents without intellectual impairment providing self-reports and 411 sentinels from 79 locations[27]. Based on sentinels reports 3.5 per 1000 young people experienced sexual assault in out-of-home care. A higher rate occurred in residential care (5.0 per 1000) when compared with foster care (2.0 per 1000) and the majority involved physical contact (90%). For adolescents twelve years old and over the differences between residential and foster care disappear (5.4 and 4.6 respectively). This means that there were more incidents involving children under the age of 12 in foster care settings and more 12 years old and over in residential settings. In total 86% of all victims were 12 years of age and over[28], 95% were girls and 24% were young people with an intellectual disability. In residential settings 50% of the perpetrators were peers and another 29% were other (outside) adolescents 21 years of age and under. Seven percent were listed as employees. Overall 91% of the perpetrators were male. The overall rate of sexual abuse for out-of-home care in the Netherlands was five times higher than the general population.

When the researchers reviewed rates for people with intellectual disabilities as a separate group the sentinels reported the rate of abuse in out-of-home care at 9.7 per 1000 people with residential care being the higher at 11.5 per 1000 people compared with foster care (7.2 per 1000). Controlling for age there were no differences between residential and foster care (9.9 and 9.3 respectively). When compared with the general population the rates of abuse in this study was nine times higher for young people with intellectual disabilities in out-of-home care when contrasted with the general population and three times higher than individuals in regular out-of-home care. Girls were more likely to be the victims of sexual abuse regardless of setting type (75 percent). Ninety four percent of the perpetrators were believed to be male and 96% of the perpetrators in residential settings were believed to be 21 years of age and under. This contrasts with foster care settings where 80% of the perpetrators were believed to foster parents or other adults.

When the researchers in the Netherlands considered self-reports the prevalence rates were significantly higher than those provided by the sentinels, with rates for all out-of-home care being 248 per 1000 people (compared with 3.5 per 1000 reported by sentinels). The majority of these reports also involved unwanted physical contact (76%). Unfortunately, self-report rates were not available of people with intellectual impairments as they were not considered able to complete the questionnaires.

The research in the Netherlands has parallels in other research but none have reported prevalence rates so clearly in out-of-home placements. Unfortunately it is difficult to determine the type of residential care referred to in the reports, although it was clear that it involved both youth custodial care as well as more therapeutic arrangements (including, potentially, residential settings associated with special schools). What was most evident in the research however, was the high rate of sexual abuse perpetrated by peers or other young people.

Another large sample prevalence study that relied on reported incidents of maltreatment (including sexual abuse) was conducted in the United States by Sullivan and Knutson (2000a). They were able to document the proportion of all children by disability status with substantiated reports of maltreatment. Merging the electronic data base of 50,278 (Sullivan and Knutson, 2000b) students in the Omaha, Nebraska, schools system with the records from the Central Registry of the Nebraska

[27] Euser et al., (2013).

[28] Also see Sequeira et al (2003). They found that of 54 adults in residential care the median age at which abuse was first known was 15 (range 4-39 years).

Department of Social Services, the Nebraska Foster Care Review Board records, and the victimization records from the county sheriff and Omaha police, Sullivan and Knutson (2000b) were able to identify 4,503 children who had experienced abuse[29].

Their sample included 1,012 children who had disabilities. Comparing the children with disabilities to their nondisabled peers, the findings indicated that the overall rate of maltreatment for nondisabled children was 11%, whereas the rate of maltreatment for those with disabilities was 31%. Children with disabilities were 3.4 times more likely to have experienced neglect, physical, emotional, and sexual abuse. The study further compared victimization within disability groups. The findings indicated that children diagnosed with behavioural disorders had the highest risk for abuse; 7 times higher for physical and emotional abuse and 5.5 times higher for sexual abuse than their nondisabled peers. They postulate that sexual abuse may have exacerbated the behavioural symptoms, thus increasing the risk for these children. Children with developmentally delay, in this study, had 4 times the risk for all four types of maltreatment; children with speech and language disabilities had 3 times the risk for sexual abuse[30]. Sullivan and Knutson (2000a) also note that children will not suffer one type of abuse but rather experience multiple forms of abuse and neglect that will almost always include emotional (or verbal) abuse.

In another large population based study Spencer and Colleagues[31] reviewed all of the children entered into the West Sussex child health data base for a 19 year period (1983-2001). Close to 120,000 children were indicated to have complete data available. For all categories, persons registered with abuse and neglect were 15 per 1000 cases recorded over the 19 year period. Within the sample were children with disabling conditions including moderate to severe learning disabilities[32], conduct disorders, non-conduct disordered psychological issues (moderate to severe), cerebral palsy and speech language disabilities. As a group, children in these categories recorded rates of physical abuse 3 to 4 times higher than non-disabled peers. People with autism or sensory disabilities did not enter significantly different rates. Similar figures were recorded for neglect (with the exception of people with speech language disabilities and non-conduct disordered psychological issues). Registration of sexual abuse was 7 times higher for young people with conduct disorders and 6 times higher in people with moderate to severe intellectual impairment. Finally registration for emotional abuse was 11 times higher for children with conduct disorders, 8 times higher for children with non-conduct disordered psychological issues and 3 and 4 times higher in children with intellectual disabilities and speech language disabilities respectively. This data from children recorded on the child protection register for abuse and/or neglect (following an investigation), indicated that children with disabilities are susceptible to abuse in multiple forums, although at varying degrees depending on disability type.

The prevalence research is clear that children with intellectual impairments and children with conduct disorders, emotional and behavioural disorders, across a range of locations (school, home or out-of-home)[33], and are at a much greater risk of abuse of any type, including sexual abuse. Furthermore, it suggests that peers are as likely to be perpetrators of abuse as others, and that for

[29] Sullivan, P. and Knutson, J. (2000a). Maltreatment and disability: A population-based epidemiological study. *Child Abuse and Neglect, 24*, 1257-1273; Sullivan, P.M. and Knutson, J. F. (2000b). The prevalence of disabilities and maltreatment among runaway children, *Child Abuse and Neglect. 24*(10), 1275-1288.

[30] Sequeira, H. and Howlin, P (2003). Psychological disturbance associated with sexual abuse in people with learning disabilities, *The British Journal of Psychiatry, 183*, 451-456.

[31] Spencer, N., Devereus, E., Wallace, A., Sundrm, R., shevov, M., Bacchus, C., and Logan, S. (2005). Disabling conditions and registration for child abuse and neglect: A population-based study. *Pediatrics, 116*, 609-613.

[32] Ie intellectual disability

[33] Ie compare Sullivan and Knutson (2000a) for school, Spencer et al (2005) for home/general and Euser et al (2013) for out-of-home care)

sexual abuse the victims are more likely to be female[34] [35]. The prevalence research usually reviews the reported cases of abuse and neglect, and suggest the actual prevalence is likely to be much higher[36] as young people fail to report abuse or reports are not taken seriously. Euser et al (2013, 2016) provides one study that reviewed very high prevalence rates when young people are able to provide anomalous self-reports. They argue that even if these figures are inflated they still represent a huge potential prevalence, especially of unreported cases of sexual abuse.

[34] Also see, Reiter, S., Bryen, D.N. and Shachar, I. (2007). Adolescents with intellectual disabilities as victims of abuse. *Journal of Intellectual Disabilities, 11*, 371-387.

[35] Timmerman, M.C. and Schreuder, P.R. (2014). Sexual abuse of children and youth in residential care: An international review. *Aggression and Violent Behaviour, 19,* 715-720. Wissink, I.B., van Vugt, E., Moonen, X., Stams, G-J,J.M, and Hendriks, J. (2015). Sexual abuse involving children with an intellectual disability (ID): A narrative review. *Research in Developmental Disabilities, 36,* 20-35.

[36] McEachern, A. G. (2012).

The vulnerability of youth with special needs to sexual abuse

It is clear from the literature that two specific groups of individuals are most at risk of sexual abuse in multiple settings. They include children with intellectual impairments or learning disabilities and children with conduct disorders and/or emotional and behavioural disorders. Wissink and colleagues reviewed 13 research articles on sexual abuse involving children with intellectual disabilities and suggested this group is "particularly vulnerable to sexual abuse due to multiple factors, including:

- Lifelong dependence on adults for care,
- Trained compliance,
- Social isolation,
- Lack of education about sexuality and sexual abuse, and
- A societal view that devalues people with disabilities"[37]

Furthermore, they suggest that some individuals may not recognise sexual abuse as something that is wrong and punishable.

Brown and Craft (1992) note that children have an increased vulnerability to sexual abuse because of their dependence on other people for personal care, the consequent imbalance of power between a carer and a person being cared for, difficulties in communicating, a lack of sexual knowledge and assertiveness, and guilt and shame about the abuse. People with learning disability have an increased vulnerability to abuse for many of the same reasons[38]. Children with learning disability are therefore even more vulnerable and at greater risk to abuse because of their dependence on others and the trust they place in their caregivers[39] [40]. Likewise, Brown (2010) notes that disabled children and young people who have a negative self-image may also be particularly susceptible to grooming and deception, and to 'tricks or treats'[41].

Garbarino (1987) suggested that children with disabilities may be particularly vulnerable to sexual abuse because of institutional living, communication problems, physical limitations, and a lack of general information and understanding of sexuality[42]. Andrews and Veronen (1993) identified eight reasons for the increased vulnerability to abuse of people with disabilities:

- increased dependency on others for long-term care,
- powerlessness as a result of denial of human rights,
- less risk of discovery as perceived by the perpetrator,
- difficulty in being believed,
- less education about appropriate and inappropriate sexuality,
- social isolation and increased risk of manipulation,
- helplessness and vulnerability in public places, and

[37] Wissink et al., (2015), p 28.
[38] Brown, H. and Craft, A. (1992). *Working with the 'Unthinkable' - Manual on the Sexual Abuse of Adults with Learning Difficulties*. London: Family Planning Association.
[39] Kim, Y. (2010). Personal safety programs for children with intellectual disabilities. *Education and Training in Autism and Developmental Disabilities*, *45*, 312–319.
[40] Lumley, V.A. and Miltenberger, R.G. (1997). Sexual abuse prevention for persons with mental retardation, *American Journal on Mental Retardation*, *101*, 459–472.
[41] Brown, H. (2010). Sexual abuse of children with disabilities, In *Council of Europe, Protecting children from sexual Violence*. Strasburg: Council of Europe Publishing, Ch 7, pp 104-105
[42] Garbarino J. (1987). *Special Children - Special Risks: The Maltreatment of Children with Disabilities*. New York: Aldine de Gruyter.

- practices of mainstreaming without consideration for each person's capacity for self-protection[43]

Young women and girls with disability may be even more vulnerable to abuse. Rosen (2006) has suggested this may be because they are not educated about their rights and responsibilities, and professionals involved in their care are uneducated and insensitive to their needs[44].

Brownlie et al (2007) point out that women and girls are disproportionately the victims of sexual assault in both disabled and nondisabled populations. They note that communication difficulties have been identified as a factor that may increase the vulnerability of individuals with disabilities to sexual assault. They report on a community sample of children with speech or language impairment, followed to age 25. Sexual assault history was assessed based on two questions from the Composite International Diagnostic Interview Posttraumatic Stress Disorder module. Women with language impairment (n = 33) were more likely than women with unimpaired language (n = 59) to report sexual abuse/assault (controlled for socioeconomic status). Sexual assault was associated with higher rates of psychiatric disorders and poorer functioning. Women with neither language impairment nor a history of sexual assault had fewer psychiatric disorders and higher functioning than women with language impairment and/or a history of sexual assault[45].

Chenoweth (1996) in a study of Australian women with disabilities noted that they are particularly vulnerable as they typically occupy positions of extreme marginalization and exclusion that make them more vulnerable to violence and abuse than other women. She also says that many of our social practices appear to be based on contradictory assumptions, such as the view that young women with disabilities are simultaneously asexual and promiscuous. She asserts that practices such as overprotection, segregation and the training of young women with disabilities to comply with requests from staff all increase the incidence of abuse and violence rather than prevent it[46].

[43] Andrews, A.B. and Veronen, L. J. (1993). Sexual assault and people with disabilities, Special issue: Sexuality and disabilities: A guide for human service practitioners. *Journal of Social Work and Human Sexuality*, 8(2), 148.

[44] Rosen, D.B. (2006). Violence and exploitation against women and girls, *Annals of the New York Academy of Sciences*, *1087*, 170-177.

[45] Brownlie, E. B., Jabbar, A., Beitchman, J., Vida, R. and Atkinson, L. (2007). Language impairment and sexual assault of girls and women: Findings from a community sample. *Journal of Abnormal Child Psychology, 35*(4), 618-626.

[46] Chenoweth, L. (1996). Violence and women with disabilities: Silence and paradox. *Violence against women*, *2*(4), 391-411.

Bullying, abuse, victimisation and the views of adolescents

Timmerman and Schreuder (2014) indicates that in residential settings, unlike schools, young people can create their own world and the influences of peers can be involuntary and inescapable. Baker and colleagues (2002) in reviewing bullying in residential settings likens them to closed systems that create peer hierarchies, increase exposure to bullying and other types of abuse, and allow easy access to personal information[47]. Timmerman and Schreuder (2014) also note that young people with a history of being sexually abused may themselves become abusers. This view is also shared in literature concerned with bullying. Sekol (2016) found that 79% of 272 young people (11 to 21 years of age) in residential facilities in Croatia were involved in bullying (either as bullies themselves, victims or both bullies and victims). However, they found that pure bullies were in the minority (8.8%) with bully/victim roles being most prevalent (47.1%), followed by pure victims (23.5% and neither victim or bully 20.6%).

The young people in Sekol's (2016) research attributed bullying to:

- less peer support (for example having a group of friends or a stable best friend),
- poor self-esteem or sense of wellbeing,
- poor relationships with staff or less staff support, and
- poor living environments[48].

In another study related to bullying in Israel Greger et al (2015)[49] found that 56 % of adolescents aged between 11 and 19 years of ages who were living in state funded residential settings reported being exposed to bullying in the previous month. The perpetrators were more often male and the victims the younger members of the residence. Peer physical aggression was lower however, in therapeutic family like settings. In their conclusions they cite important work by Barter and colleagues[50] that focus on residential settings and the relationships forged with staff:

> In family-like placements the likelihood of nurturing strong bonds is higher. Adolescents in such settings may be encouraged to report victimization and seek help more strongly… it might also be that settings with familial elements allow for more effective supervision of peer violence than traditional settings[51].

Greger et al (2015) also conclude that not just environment but poor staff training may increase the risk of being victimized in residential settings.

Self-reporting by adolescents has been helpful in understanding those elements that work for or against peer aggression and victimisation in residential settings. For example, Soenen et al (2014)[52]

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[47] Baker, L., Cunningham, A. and Male, C. (2002). *Peer-to-peer aggression in residential settings: Increasing understanding to enhance intervention.* London: Centre for Children and Families in the Justice System.

[48] Sekol, I. (2016). Bullying in adolescent residential care: The influence of the physical and social residential care environment. *Child Youth Care Forum, 45,* 409-431.

[49] Greger, K., Myhre, A.K., Lydersen. S. and Jozefiak, T. (2015). Previous maltreatment and present mental health in a high-risk adolescent population. *Child Abuse and Neglect, 45*, 122-134.

[50] Barter, C., Reynold, E., Berridge, D., and Cawson, P. (2004*). Peer Violence in Children's Residential Care*. New York: Palgrave Mcmillan.

[51] Khoury-Kassabri, M and Attar-schwartz, S. (2014). Adolescents' reports of physical violence by peers in residential care settings: An ecological examination. *Journal of Interpersonal Violence, 29*(4), 659-682. Pp 676 Citing Barter et al., (2004).

[52] Soenen, B., D'Oosterlinck, F., and Broekaert, E. (2013). The voice of troubled youth: Children and adolescents' ideas on helpful elements of care. *Children and Youth Services Review, 35*, 1297-1304.

interviewed 50 students with emotional and behavioural issues in a residential setting in Flanders. Each residential unit housed 12 to 14 youth ranging in age from 7 to 18. Each residence was linked to a special school. The students identified 8 key areas that contributed to alleviating conflict and avoiding abuse. These included:

- Create and maintain a positive/calm and less chaotic atmosphere.
- Allow for privacy where individuals can have time alone (ie not always be part of a group).
- Provide complete supervision, especially in playgrounds and areas of the home where supervision can become lax.
- Have key staff available to talk over problems.
- Develop trusting relationships with staff.
- Staff should be available both in terms of being able to talk with individuals but also do pleasant activities and have fun.
- Have clear rules and boundaries – these should be clearly articulated, be righteous and equal for everybody and administered by all staff in the same manner.
- Staff should avoid being overly strict or rigid, listen appropriately and avoid punitive approaches.

As well as these observations made by the students Soenen et al (2013) suggest that using communication to talk through problems and incidents can provide students with valuable insights about their own behaviour. The authors also believe that working to develop a professional and focused staff team is key to not only working effectively with youth but also to reduce conflict and aggression. They state:

> We plead for the implementation of clearly elaborated and structured methods: both methods with a focus on communication … [and] with a focus on providing structured rules and boundaries. These methods should provide a well-considered balance between providing individual attention and treating the youth as a group. Professionalization of frontline staffs' position based on coaching from their supervisors, together with smaller group sizes and sufficient available staff, will be necessary conditions for this implementation to succeed[53].

Similar results are noted in a study by Harder et al (2013) in the Netherlands where adolescents and staff were asked about the determinants of positive (and negative) relationships. They found that the treatment skills of either residential care workers and special education teachers was positively associated with the relationship quality between the adolescent and the care worker/teacher. Treatment skills included being clear, committed, working in partnership (rather than authoritarian), being reliable, fitting in with the person, being respectful and giving positive feedback[54]. The authors also noted that students who were able to gain positive relationships with staff were more likely to work effective with them and return to their homes of origin quicker than students who failed to form positive bonds. The implications for the current review (and other articles that focus on the quality of the relationships with staff and the therapeutic focus of the residential/school settings) is the increased security experienced by youth in out-of-home placements when these things are in place.

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[53] Soenen et al (2013), p. 1303.

[54] Harder, A.T., Knorth, E.J., and Kalverboer, M.E. (2013). A secure base? The adolescent-staff relationship in secure residential youth care. *Child and Family Social Work, 18*, pp 305-317. The authors also warn against generalising this result due to homoscedasticity issues in the sample, however, the trend throughout the article is consistent with other work as noted in this paper and in the conclusions of the authors.

Barriers to Disclosure of Abuse

Brown (2010) note disclosure of abuse may be particularly difficult for people with disabilities. People with disabilities in a position of care dependency may find it difficult to disclose abuse, particularly if they do not see they have any realistic care alternatives. The NDA expert seminars noted that people with disabilities may feel disempowered from making complaints, may have little contact with the outside world, may find it more difficult to communicate, or to be taken seriously if they do complain. So people with disabilities may be easier for abusers to victimise.

Definitions of sexual abuse are also problematic. Some are limited to abuse of children perpetrated by adults, while others include abuse by peers, and some register only penetrative sex while others include any unwanted and/or coerced sexual activity.

The capacity of the criminal justice system to hear and respond to complaints from people with disabilities is another factor affecting disclosure. The symptoms of abuse may be attributed to a person's disability, and thus discounted[55].

Barriers to Reporting Abuse

The Irish National Disability Authority identifies the following barriers to reporting of abuse by children with intellectual disability:

- The child being unable to name and recognise abuse due to a lack of experience, awareness or knowledge.
- Past experience of care or medical practices that undermined or transgressed personal boundaries and bodily integrity.
- Disempowerment and low-esteem.
- Isolation (including physical, communication, social).
- Having one's credibility questioned, particularly persons with intellectual and mental health disabilities.
- The capacity of staff with whom they are in contact to detect and respond to abuse.
- The capacity of the justice system and other redress mechanisms to provide an accessible system to deal with complaints from people with disabilities .
- The absence of a system of independent advocacy particularly in closed environments.
- Negative attitudes .
- Failure to of staff to identify where abuse is occurring within intimate relationships .
- Fear of consequences of disclosure including retaliation, rejection or being moved from home or service environment. These fears are likely to be particularly significant if the

[55] McGee, H., Garavan, R., de Barra, M., Byrne, J., and Conroy, R. (2002). *The SAVI Report: Sexual abuse and violence in Ireland.* Dublin: Liffey Press, p 244; Balogh et al., (2001).

person is reliant on the abuser for the activities of daily living[56].

Lack of appropriate support services has also been identified as a factor by Paul et al (2004) in UK coeducational residential special schools. They found that the schools believed they did not always get the degree they should have from external services, including child protection services; particularly with reference to child protection issues and disability. Paul et al (2004) were also told that child protection concerns were much harder to address because of child protection services and legal system attitudes to disabled children and particularly to children whose communication was non-verbal[57].

Andrews and Veronen (1993) has listed four requirements they see as enabling effective abuse victim services for women with disabilities which are equally valid for children in residential services:

- Service providers need to provide adequate assessment of survivors, including questions about disability-related issues.

- Abuse service providers should be trained to recognize and effectively respond to needs related to the disability, and disability service providers should be trained in recognizing and responding to physical and sexual trauma.

- Barriers to services should be eliminated by providing barrier-free information and referral services, by ensuring physical accessibility to facilities, by providing 24-hour access to transportation, to interpreters, and to communication assistance, and by providing trained personnel to monitor risks and respond to victims receiving services through disability programs.

- People with disabilities who are dependent on caregivers, either at home or in institutions, may need special legal protection against abuse[58].

[56] Irish National Disability Authority website, accessed 27 Jan 2013 at http://www.nda.ie/cntmgmtnew.nsf/0/CE957ED7DA23464B802576CB005B809A/$File/SexualAbuse2008_02.htm

[57] Paul, et al (2004), p. 8.

[58] Andrews, A. B. and Veronen, L. J. (1993). Sexual assault and people with disabilities. Special issue: Sexuality and disabilities: A guide for human service practitioners. *Journal of Social Work and Human Sexuality, 8(2)*, 137-159.

Incidence of sexual abuse in residential special schools

Few studies have looked specifically at the risks in coeducational schools. Fyson (2009) surveyed 40 state and independent schools for children with learning disability in four local authorities in England to explore the extent to which special schools were aware of pupils engaging in sexually inappropriate or abusive behaviours. Her sample did include both day and residential schools but, unfortunately, to preserve anonymity for the relatively small sample of 26 who responded, survey respondents were not asked identifying questions about their school. Results for residential and day schools are therefore not presented separately[59]. Fyson examined:

1. The nature and frequency of such behaviour and the locations in which it may arise;
2. Staff responses to these behaviours, including adherence to any available policy guidelines;
3. How decisions are made about whether and when to request help from outside agencies and the barriers to seeking such support. Her questionnaire asked about school policy with regard to sexually inappropriate behaviour; the type, frequency and location of inappropriate or abusive behaviour known to have occurred between pupils; and whether, and from what source, schools had sought help in responding to these behaviours.

Fyson found that most special schools (88%) were aware of incidents of sexually inappropriate or abusive behaviour occurring between their pupils during the school day. In most schools, such incidents were known to happen on a regular basis. Two-thirds of schools reported sexually inappropriate or abusive behaviours occurring between pupils at least once per term, and almost one-fifth reported incidents occurring at least once a week. Only a small minority of schools (12%; n = 3) asserted that sexually inappropriate or abusive behaviour never occurred and, of these, one was careful to explain that this was simply because the profound nature of their pupils' disabilities precluded them from independent physical interactions.

Table 1: Frequency of sexually inappropriate or abusive incidents:

	% of schools	Cumulative % of schools
Weekly	19 (n=5)	19 (n=5)
Monthly	27 (n=7)	46 (n=12)
Each term	19 (n=5)	65 (n=17)
Yearly	8 (n=2)	73 (n=19)
Less Often	15 (n=4)	88 (n=23)
Never	12 (n=3)	100 (n=26)[60]

Incidents happened at all times of the school day and in a variety of locations. Although incidents were most often identified as occurring within school buildings (77%), they also occurred in over half of school playgrounds (54%) and around a third (35%) of school transport. Most other incidents arose during school trips. Schools reported a variety of different types of sexually inappropriate or abusive behaviour. The most frequently recorded category, 'inappropriate touch', was reported in 85% (n = 22) of schools. However, this term could be used as a catch-all for a wide variety of actual incidents, ranging from very minor or even accidental physical contact through to aggressive sexual groping. In general, behaviours that might be classified as sexually inappropriate such as verbal

[59] Fyson, R. (2009). Sexually inappropriate or abusive behaviour among pupils in special schools. *British Journal of Special Education, 36*(2), 85-94.
[60] Ibid, p 87.

sexual harassment and 'flashing' were more likely to be reported than incidents which were unequivocally abusive. However, some very serious acts of abuse – including rape – had occurred in a small proportion (15%; 4 of the schools surveyed).

Table 2: Nature of incidents reported

	% of schools
Verbal sexual harassment	50 (n=13)
Exposure (flashing)	54 (n=14)
Masturbation	58 (n=15)
Inappropriate touch	85 (n=22)
Actual or attempted anal or vaginal penetration	15 (n=4)[61]

Fyson found that despite the high frequency of incidence of abuse, only 19% of schools had a specific policy on sexual behaviour.

[61] Ibid, p 88

New Zealand Research into Sexual Abuse of Children with Intellectual Impairment

The major New Zealand research in this area has been that conducted by Professor Freda Briggs. In 1991 together with Associate Professor Russell Hawkins she initially reviewed the Keeping Ourselves Safe (KOS) programme in New Zealand. They interviewed 255 Intermediate School students aged 10-12 years and their parents in eight schools in both the North and South Islands. They found that 80% of girls identified as having learning problems had already been sexually abused more than once: All of these cases had been substantiated. The abusers of children with developmental delay and learning difficulties were local youths (pack rapists), close male relatives and brothers' 'best mates'. International research findings, especially from Canada and the UK, suggest that from 70-80% of children with disabilities suffer from sexual abuse[62].

Briggs and Hawkins (1991) found that New Zealand parents had unrealistic expectations relating to children's abilities to protect themselves:

> For example, despite giving children no information about sexual misbehaviour, they expected children to know intuitively that it was wrong and reportable. Secondly, despite relating goodness to obedience, they expected children to disobey sex offenders regardless of their age, relationship or position of authority. In addition, despite teaching children to keep secrets, they expected them to break the rule when secrecy involved not-previously-mentioned sexual abuse. And although parents became angry when children talked about genitals, they expected their children to break the taboos and immediately report sexual misbehaviour to them. And of course, children will not do that unless they know, from past experience, that the adults can cope with the information and will not become angry and blame them. Some children never tell[63].

This is consistent with Australian evidence they found in the general population that few people talk about their experiences of sexual coercion and fewer still talk to a professional such as a teacher, social worker or doctor[64]. Briggs and Hawkins found that of 198 Australian male victims of sexual abuse only 26 reports were made, 25 by mothers and one reported to a teacher. Of those, 'only one boy was believed and the rest were punished'[65].

In a US study Balogh et al (2001) had found that in 30% of the cases of sexual abuse they found in young people with an intellectual disability referred to a child and adolescent psychiatric hospital, the abuse had only been identified after admission[66].

Briggs and Hawkins go on to say:

> Eight percent [of parents of intermediate school children] informed us that their children had stopped attempted sexual abuse and reported this to them. Only half of the parents

[62] Briggs, F. (2002). *To what extent can "Keeping ourselves safe" protect children? PUB L 169.* New Zealand Police, Wellington.
[63] Briggs F. and Hawkins R (1991) Evaluation of 'Keeping Ourselves Safe' Curriculum Used with Children of 5–8 Years in New Zealand Schools: Report for the Commissioner of Police and Ministry of Education, New Zealand. University of South Australia, Magill Campus, p 4
[64] De Visser R.O, Smith A.M.A, Rissel C.E, Richters J. and Grulich A.E. (2003). Sex in Australia: Experiences of sexual coercion among a representative sample of adults. *Australian and New Zealand Journal of Public Health, 27*(2), 198-203.
[65] Briggs and Hawkins (1991). p 4
[66] Balogh et al (2001).

> reported this to the authorities. Too many parents reported that principals tried to "cover up" sexual abuse that happened on school premises, irrespective of whether offenders were employees or students. A parent complained that sexual abuse by a school caretaker had been ignored[67].

Briggs and Hawkins reported that the children of Police Education Officers, who provide the KOS programme in schools, and child protection workers were no better informed than others:
Their parents admitted that they had never discussed child protection issues at home. They assumed (wrongly) that their work would 'rub off' on their children. It hadn't![68]

Briggs and Hawkins say international research shows that victims with disabilities are less likely to be believed than non-disabled children when they report abuse (for a variety of reasons). They said a weakness of the KOS programme was that it instructed children to report abuse to people they trusted. Initially, they found, children only told their mothers, none of whom believed or supported them[69].

Briggs and Hawkins noted that more severe forms of abuse (e.g. involving penetration) were associated with greater severity of disturbance, a finding that is also reported in studies of child abuse in the general population, for example Rodriguez et al (1996)[70].

Briggs and Hawkins conclude that the incidence of sexual abuse of young people with an intellectual disability is alarming, not the least because there is clear evidence that people who are abused go on to abuse.

Balogh et al (2001) demonstrated this relationship in their review of young people with intellectual disabilities admitted to a child and adolescent psychiatric hospital over a five-year period. They found 14% had been a victim or a perpetrator of sexual abuse. Victimization alone occurred in 49% of these 43 cases, perpetration alone in 14%, and both victimization and perpetration in 37%. Sixty five percent of the 17 male perpetrators had been victims. There was only one instance of a victim being abused by a female but there were five girls who had been perpetrators. All had previously been victims[71].

McCormack et al (2005) analysed all of the 250 allegations of sexual abuse involving intellectual disability service users as victims or perpetrators of sexual abuse over a 15-year period in a large Irish community-based service. Following multidisciplinary investigation, almost half (47%) of all allegations of sexual abuse were confirmed (n = 118). In confirmed episodes, more than half the perpetrators were adolescents and adults with intellectual disabilities, while almost a quarter were relatives. The most common type of abuse was sexual touch, although 31% of episodes involved penetration or attempted penetration. The most common location was the family home, followed by the day service and public places[72].

Read and Read (2009) also found that people with learning disabilities are over-represented in sex offences. But they point out that sexual offences carried out by people with a learning disability are likely to be offences such as exhibitionism or indecent assault, rather than more serious crimes such

[67] Briggs and Hawkins (1991). p 10.
[68] Ibid, p 4.
[69] Ibid, p 10.
[70] Rodriguez, N., Ryan, S., Rowan, A. and Foy, D.W. (1996). Posttraumatic stress disorder in a clinical sample of adult survivors of childhood sexual abuse, *Child Abuse and Neglect*, *20*(10), 943– 952.
[71] Balogh, et al (2001).
[72] McCormack, et al. (2005).

as rape. And in their research concerned with murder and arson they have found that the predominant diagnoses of people with an intellectual disability who sexually offend are Disruptive Behaviour Disorders. They warn however that this overrepresentation should be treated with some caution as there may be methodological problems within studies that support this finding[73].

Fyson (2009) also notes that reports, overviews and commentaries about young people who sexually harm others have repeatedly noted that young people with learning disabilities are significantly over-represented within this group. She notes that most of the studies upon which these assertions are founded have focused on young people who have been referred to specialist services because of their sexually harmful behaviour. They have found that somewhere between one-fifth and one-half of young people referred to such services are identified as having some degree of learning disability. Although the precise reasons for this over-representation remain uncertain, Fyson identified a number of factors which she believes contribute towards this imbalance[74]:

Firstly, children with any type of disability are more likely than non-disabled children to have been abused (Sullivan & Knutson, 1998[75] & 2000[76]; Westcott & Jones, 1999[77]). This holds true for all categories of abuse: physical abuse, sexual abuse, emotional abuse and neglect. It is also known that children with disabilities who experience abuse are likely to be abused for longer than their non-disabled peers (Westcott & Jones, 1999), and that, once abuse is discovered, interventions from statutory services are less decisive (Cooke, 2000[78]). There is no direct causal relationship between experiencing abuse and becoming a sexual abuser, but high rates of previous victimisation are noted among populations of young people who sexually harm others, and this trend is even stronger for young people with learning disabilities.

Secondly, the lives of young people with learning disabilities tend to be more heavily monitored than those of other youngsters. This may mean that, when they display sexually inappropriate or abusive behaviours, they are more likely than their non-disabled peers to be caught (McCurry et al, 1998[79])[80]. Thirdly, young people with learning disabilities may find it harder to understand the complex and fluid boundaries that divide acceptable and unacceptable sexual behaviours, with the result that they may act in ways which are sexually inappropriate, or even abusive, without understanding the impact or consequences of what they are doing. In some cases, this difficulty may be unwittingly exacerbated by parents and carers, some of whom may fail to expect the same standards of behaviour as they would from young people without disabilities.

Finally, there is emerging evidence to suggest that the overrepresentation of young people with learning disabilities among referrals to services of young people who sexually harm others may be a consequence of biased referrals. Two recent studies have suggested that a lack of skills, knowledge and – above all – confidence among professionals leads to a greater tendency to refer young people

[73] Read, F. & Read, E. (2009). Learning Disabilities and Serious Crime – Sex Offences. *Mental Health and Learning Disabilities Research and Practice*, *6*(1), 37-51, p 38.
[74] Fyson (2009). p 85.
[75] Sullivan P. and Knutson J. (1998). The association between child maltreatment and disabilities in a hospital-based epidemiological study. *Child Abuse and Neglect, 22*, 271-288.
[76] Sullivan P, and Knutson J. (2000a) Maltreatment and disabilities: a population-based epidemiological study. *Child Abuse and Neglect, 24*, 1257-1273.
[77] Westcott, H., and Jones, D. (1999). The abuse of disabled children. *Journal of Child Psychology and Psychiatry, 40*, 497-506.
[78] Cooke, P. (2000). *Final Report on Disabled Children and Abuse*. Nottingham: The Ann Craft Trust.
[79] McCurry, C., McClellan, J., Adams, J., Norrei, M., Storck, M., Eisner, A., and Breiger, D, (1998). Sexual Behaviour Associated with Low Verbal IQ in Youth who have Severe Mental Illness. *Mental Retardation, 36*(1), 23-30.
[80] Fyson, R. (2009). P. 85

with learning disabilities to specialist services. Those who work with young people with learning disabilities in educational or social settings may not feel able to work effectively around issues of sexuality. Likewise, professionals working in child protection or youth offending teams may not believe that they have the skills or knowledge to work with a young person with a learning disability.

Fyson (2009) says the over-representation of those with learning disabilities within populations of young people who sexually harm is therefore created by a complex interplay between differential rates of child abuse and differences in professional awareness of, and responses to, inappropriate or abusive sexual behaviours exhibited by different groups of young people. The disparities noted within treatment populations may or may not reflect actual differences in behaviour between young people with and without learning disabilities, but nevertheless cause concern: 'One of the key changes in the response to adolescent sexual aggression over the past decade is a rapid increase in the number of young people with learning disabilities being identified and referred for intervention'[81].

Fyson (2009) points out that, during adolescence, many young people will display behaviours that could be regarded as sexually inappropriate; a smaller proportion (mostly male) will behave in ways that are sexually harmful to others; and a small minority of these will go on to engage in lifelong sexual offending. A significant proportion, around one-third, of child sexual abuse is perpetrated by adolescents against younger children[82]. Crime statistics show that young people are responsible for between one-fifth and one-quarter of all sexual offences; but when cautions and reprimands as well as court convictions are taken into account, young people are responsible for almost two-thirds of reported sexual crimes[83].

Fyson notes that as they grow older and pass through puberty, most young people – including those with learning disabilities – will want to begin exploring their own burgeoning sexuality; many will experience their first sexual relationships. These initial forays into the world of adult sexual relations are seldom easy, and young people with learning disabilities may experience particular social pressures arising from their position in a society which often views people with learning disabilities as, by turns, either asexual or the possessors of monstrous sexual appetites[84].

However, Fyson (2009) says, regardless of its causes, the fact that young people with learning disabilities may exhibit sexually inappropriate or abusive behaviours should be of concern to all parents and professionals. Preventing behaviours which are merely inappropriate from escalating into acts of abuse is important not only because of the harm that such acts cause to others, but also because being labelled a 'sexual abuser' will undoubtedly further damage the already limited life opportunities of a young person with a learning disability[85]. It is therefore important that special schools are aware of the possibility that pupils may engage in sexually inappropriate or abusive behaviours. Previous studies have highlighted that children can be at risk of abuse in schools or other institutional settings but have typically limited their scope of inquiry to abuse perpetrated by professionals, rather than considering the risks which pupils may at times pose to one another[86]. Doyle (2004) however cautions that in reviewing the incidence sexual offending behaviour in people

[81] Ibid, p 86

[82] Cawson, P., Wattam, C., Brooker, S., Kelly, G. (2000). *Child Maltreatment in the United Kingdom: a Study of the Prevalence of Child Abuse and Neglec*t. London: NSPCC

[83] Fyson, R. (2009), p 86.

[84] Ibid, p 86.

[85] Fyson, R., Eadie, T., and Cooke, P. (2003). Adolescents with learning disabilities who show sexually inappropriate or abusive behaviours: Development of a research study. *Child Abuse Review, 12 (5), 305-314.*

[86] Doyle, D. M. (2004). The differences between sex offending and challenging behaviour in people with an intellectual disability. *Journal of Intellectual & Developmental Disability, 29*(2), 107-118.

with an intellectual disability we need to differentiate between that and challenging behaviour. He suggests that when clinicians attempt to view sexual offending from within the framework and underpinning philosophy of the challenging behaviour model the magnitude of the mismatch emerges. In his paper he compares the notions of intent, criminal intent and communicative intent. The implications of wrongly interpreting challenging behaviour as sex offending behaviour are highlighted. He also proposes functional behaviour analysis as a technique that may aid in the assessment of sex offending[87].

[87] Fyson (2009), p 86.

The particular issues concerning the vulnerability of students in residential special schools

Much of the research into children and young people in out-of-home care provides scant information on the style of support provided either in terms of the size of the residential accommodation, its function or its relationship with special education. The research does distinguish between foster home and residential care and on occasion provides distinctions between residential settings for juvenile justice, social welfare and mental health services. Only in a few cases have the papers indicated when the residential accommodation was attached to special schools[88]. The studies also rarely distinguished between the composition of residential placements particularly with regard to young people with intellectual impairments on the one hand and those with conduct disorders and/or emotional/behavioural disturbance on the other. Thus, some residential situations with associated special schools may cater to various mixes of young people. Composition within a single group may have particular ramifications for the type and intensity of support required.

There are other issues that also influence the vulnerabilities specific to children in residential special schools. Paul et al (2004) note these children:

> ... can encounter a wide range of care staff, outside professionals, volunteers and other adults. This brings advantages but also presents risks. The Utting review cites one study of a school for children with multiple disabilities in which some children had over 40 carers and few had less than eight (Marchant, cited in Utting 1997). In addition, disabled children living in residential special schools will often be placed a long distance from families, who may visit infrequently: physical and social isolation brings with it certain dangers[89].

The UK Support Force for Children's Residential Care, set up to address some of the staff recruitment and training issues identified in several enquiries into children's homes also addressed the issue of isolation:

> The context in which abuse occurred usually involved an exclusion or absence of outside contact and a lack of effective scrutiny by external managers. In addition, the accepted pattern of relationships and behaviour within the home often contributed to an environment in which abuse could pass undetected or unreported or be accepted as 'normal' behaviour'[90] .

Utting (1997) studied two residential special schools for disabled children and reported that the children mostly felt safe, were in contact with their parents and saw living away from home as a positive option[91]. But Paul et al (2004) warn that this review and a Scottish Children's Safeguards Review (Scottish Office 1997) endorse the view that the particular circumstances and the extra vulnerability of disabled children mean that we need to be especially vigilant. They note that:

> The Utting review stresses the importance of residential services having 'an explicit commitment to child protection together with very clear definitions of good practice'. The children interviewed for the review made their own suggestions for child protection,

[88] For example, Soenen et al., (2013) focused on smaller 12-14 bed residential environments specifically connected with special schools.
[89] Paul et al (2004). P. 13.
[90] *Support Force for Children's Residential Care* (1995) *Final report*. Pp. 4 para. 3.56
[91] Utting, W. (1997). *People Like Us: The Report of the Review of the Safeguards for Children Living Away from Home*. London: HMSO.

> including a choice of adults to approach for support, a culture of openness, adequate security measures and vetting of staff, and ensuring that children know their rights[92].

Paul et al conclude that:

> The review of the relevant literature has shown that firstly, although no systematic figures are available estimations have indicated that thousands of disabled children experience many different forms of out of home placement, the main one being residential special schools. However, we know very little about these children's experiences of the care they receive. The limited research and practice literature available does suggest that disabled children are especially vulnerable to institutional abuse. Disabled children experience a diverse range of out of home provision. How they are protected from abuse by both procedural and practice safeguards contained within these different settings, and how adequate these are, is unknown. The nature of a child's disability may mean they are especially vulnerable to particular forms of abuse and certain targeting strategies, however little research exists to inform our knowledge of this[93].

The only comparative material Paul et al (2004) found for their study of coeducational residential special schools was from a small study by Westcott (1993) looking at the National Society for Prevention of Cruelty to Children (NSPCC) experience of working with children who had been abused in an institutional setting[94]. Westcott and Cross (1996) later took data from this study relating specifically to disabled children. The majority of the 31 disabled children (68%) had been abused whilst in their school placements or in residential homes (29%). Twenty four were male and seven were female. Although the small sample size here makes it difficult to generalise from this study, Westcott and Cross do point out that different forms of abuse have different contexts. Sexual abuse commonly results from deliberate targeting of vulnerable children, while other forms may have more to do with inadequate resourcing or staff training, leading to the recruitment of unsuitable staff, to staff being under pressure, or to insensitive, institutionalised care practice which becomes abusive[95].

[92] Paul, et al (2004).
[93] Ibid pp 18.
[94] Westcott, H. (1993). *The Abuse of Children and Adults with Disabilities*. London: NSPCC.
[95] Westcott and Jones (1999).

Vulnerability of children in special schools to abuse by staff or volunteers

Children in residential special schools are most vulnerable to abuse by staff and volunteers working with them. An early but comprehensive study in the USA found that of the 163 reported allegations of institutional abuse in their mental retardation facilities (their terminology), between 1986 and 1989, 62% related to physical abuse, 13% related to adult to child sexual abuse and 3% to child to child sexual 'contact'[96]. Sobsey (1994) hypothesises that exposure to multiple carers as in a residential setting may increase vulnerability by increasing the statistical risk of the child encountering a paedophile. She found that two-thirds of adult offenders against children with disabilities gained access to them through special services for disabled people, with more than half the offenders being paid staff or volunteers[97].

Colton (2002) notes that confidence in the public care system in the United Kingdom (UK) was shaken by numerous and widespread scandals in the 1980s and 1990s surrounding the abuse of children and young people, particularly those in residential child care institutions (see for example Brannan et al, 1993[98]). Colton examines factors associated with such abuse, identifying them as:

- Failings in relation to staff recruitment, training, and supervision .
- Ineffective management and systems of accountability.
- The development of inappropriate institutional cultures.
- Public ambivalence towards children in care.
- The slow footed response to the threat posed to children and young people by dangerous men and other youngsters in care.
- Long-term policy failure to develop coherent and integrated systems of child welfare in the UK[99].

Gallagher (2000) notes that systemic abuse in institutional care is relatively uncommon, constituting a small proportion of all child protection referrals in the UK. But some cases involve large numbers of victims and abusers. Institutional abuse cases he studied shared some characteristics with the majority of abuse cases, but he also noted important differences, such as the proportion of male victims and the extent to which abusers used techniques of targeting and entrapment. He also found institutional abuse occurred in a wide variety of settings and sectors and was perpetrated by a range of occupational groups.

In the UK a number of inquiries were undertaken into incidents of abuse of children in institutional care[100]. These culminated in the launch of the Every Child Matters framework[101], constituting an important UK policy initiative in relation to children and services provided for them. The framework outlined the value of programmes providing services for children and young people in order to minimise risk.

Sobsey (1994) found that two thirds of offenders who had abused children with disabilities contacted their victims through special services for the disabled, with more than half of them being

[96] New York State Commission report on Quality of Care for the Mentally Disabled (1992). in Paul (2004).
[97] Sobsey, R. (1994). *Violence and abuse in the lives of people with disabilities.* Baltimore: Paul H Brookes
[98] Brannan, C., Jones, J.R. and Murch, J.D. (1993). Lessons from a residential special school enquiry: Reflections on the Castle Hill report. *Child Abuse Review, 2*(4), 271–275.
[99] Colton, M. (2002). Factors associated with abuse in residential child care institutions. *Children & Society*, *16*(1), 33–44.
[100] Corby, B., Doig, A. and Roberts, V. (2001). *Public Inquiries into Abuse of Children in Residential Care*, London: Jessica Kingsley Publishers.
[101] HM Government (2004). *Every child matters.*

paid staff or volunteers. Sobsey concludes that much of the risk of sexual abuse for those with disabilities may result from their exposure to the support systems they use[102].

Much work has been done in recent years in the UK in response to the inquiries into the abuse of children in residential care. The National Society for Prevention of Cruelty to Children (NSPCC) has addressed the issue of staff abusing children in some detail. They propose:

- Recruitment and selection procedures for staff and volunteers to help screen out and discourage those who are unsuitable to work with children.

- That Boards of trustees have training in and comply with safe recruitment practices for staff, volunteers and others who come into contact with children in their schools.

- Use of Value Based Interviewing as part of the selection process which would help to identify those candidates who have positive safeguarding attitudes and values and who are therefore more likely to identify and address safeguarding issues at work, creating a safer environment for children .

The NSPCC also points out that such rigorous selection processes make it clear to all applicants at the outset that the school is proactive in creating a culture of safeguarding within the school. In the UK, the NSPCC offer Value Based Interviewing training to schools on request.

NSPCC further notes that safeguarding policies and procedures create a positive and safe environment for children. They say it is vital for service providers to have:

- An understanding that the safety and welfare of the child is the priority and that any concern about the behaviour of others must be reported immediately.

- Clear guidelines or a code of conduct for all those involved: staff, volunteers, pupils and parents/carers.

- Everyone involved in their school community knowing what behaviour is acceptable and what is not.

- Individuals who are not adhering to these clear expectations being challenged.

- Clear procedures in place for dealing with child protection concerns, disclosures or allegations in order to support staff/volunteers, young people and parents through the process of reporting any concerns.

- Accurate records kept of all incidents and concerns arising in relation to members of staff or volunteers.

- All staff, volunteers and parents aware of the appropriate avenues for pursuing complaints when they are unsatisfied with the internal response to their concern.

The UK Department for Children, Schools and Families issued *Guidance for Safer Working Practices for Adults who Work with Children and Young People in Educational Settings* in March 2009 to

[102] Sobsey (1994).

promote safer working practices for adults who work with children and young people in education settings. They propose safeguarding training to ensure that staff in schools have:

- A good understanding of safeguarding issues including the causes of abuse, neglect or harm.
- Knowledge of the signs/indicators that should alert them to the possibility of abuse including grooming behaviour.
- A clear understanding of how to effectively respond when they have concerns or receive a disclosure including appropriate communication with children and record keeping requirements.
- A good understanding of the schools reporting procedures including the role of the Designated Senior Person (in Northern Ireland these roles are the Designated and Deputy Designated Teachers), the role of the Local Authority Designated Officer (LADO) (or the Child Protection Support Service for Schools (CPSSS) in Northern Ireland) and the roles of external agencies that may need to become involved during the process.
- Opportunities to explore issues such as professional practice and individual staff responsibilities, the use of whistle-blowing procedures and dealing with confidentiality.

The UK NSPCC proposes that preventative education in schools should work to:

- Help children and young people understand what constitutes abuse and to raise awareness of behaviours that are of concern or unacceptable.
- Teach children and parents how to seek help appropriately.
- Not avoid the potentially sensitive area of sexual abuse as research indicates that there are gaps in children's knowledge with regard to keeping themselves safe from sexual abuse.
- Include a comprehensive e-safety education programme.
- Promote a culture of openness and transparency which in turn encourages vigilance and a sense of shared responsibility for the safeguarding of pupils.
- Promote listening and open communication where all are facilitated to communicate about worries, are listened to and their concerns are taken seriously.
- Contact names and numbers for internal and external support services should be made available to ensure that pupils and their families know who they can talk to if they are worried. Those who work in schools should be assured that they can share any concerns about the conduct of colleagues and that these will be received in a sensitive manner[103].

[103] NSPCC. Safeguarding in Education Service (2012). *The role of schools, colleges and academies in protecting children from grooming and entrapment*. [London]: NSPCC.

Strategies for Minimising Sexual Abuse in Coeducational Residential School

Cooke and Sinason (1998) noted that following recognition in the late 1980s that children with disabilities were being abused, guidelines were produced in the UK and voluntary organisations such as the National Association for the Protection from Sexual Abuse of Adults and Children with Learning Disabilities (NAPSAC), the Association for Residential Care (ARC) and Voice UK made efforts to provide more protection for this vulnerable group[104].

However the UK Residential Special Schools National Minimum Standards which came into force on 1 January 2013 address problems of bullying but contain no specific measures for monitoring or preventing inappropriate sexual behaviour[105]. A revised document has the same omission but does suggest that school maintain a staff pool of both genders[106].

The American Academy of Pediatrics Committee on Children with Disabilities (1996) advises that to combat the increased risk to children with developmental disabilities they need to be given information about sexuality, sexual abuse and what to do when it happens. Without such education, they say, they remain vulnerable victims[107]. Bambara and Brandtlinger (2002) and Sparks (date unknown) present evidence to suggest that without sexuality education, children and adults with developmental disabilities are at a significantly greater risk of sexual abuse, unwanted pregnancies, sexually transmitted diseases, and poor relationships[108] [109].

Newman et al (2000) recommend social policy that does not reinforce stigma but provides accurate, respectful, and necessary protections[110].

Brown (2002) analysed social issues in terms of the ways in which disabled children are placed at more risk than other children in settings that have not attended to safety, for example in the design of buildings or the recruitment of staff[111].

In their ABCD (Abuse and Children who are Disabled) guide to protecting disabled children from abuse, Cross et al (1993) state that an explicit commitment to child protection should be

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[104] Cooke, L.B. and Sinason, V. (1998). Abuse of People with Learning Disabilities and Other Vulnerable Adults, *Advances in Psychiatric Treatment*, *4*(2), 119-125.

[105] UK Department of Education (2013). *Residential Special Schools National Minimum Standards*, accessed at: https://www.education.gov.uk/publications/eOrderingDownload/DFE-00125-2012.pdf

[106] UK Department of Education (2015). *Residential Special Schools National Minimum Standards*, accessed at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/416188/20150319_nms_rss_standards.pdf

[107] Committee on Children with Disabilities (1996). Sexuality education of children and adolescents with developmental disabilities, *Pediatrics, 97*(2), 275-278.

[108] Bambara, L.M., and Brantlinger, E. (2002). Toward a healthy sexual life: An introduction to the special series on issues of sexuality for people with developmental disabilities. *Research & Practice for Persons with Severe Disabilities, 27*(1).

[109] Sparks, S., (no date). *Sexuality and Individuals with development Disabilities: Disabilities Research Position Papers*, Board of Directors of the Council for Exceptional Children – Division on Developmental Disability, USA.

[110] Newman, E., Christopher, S.R. and Berry, J.O. (2000). Developmental disabilities, trauma exposure, and Post-Traumatic Stress Disorder. *Trauma Violence and Abuse,* (2), 154-170.

[111] Brown, H. (2002). *Vulnerability and protection,* Unit 23 K202 Community Care School of Health and Social Welfare, Open University, Milton Keynes.

incorporated within the central aims of the institution[112]. Marchant and Cross (1993) highlighted six steps necessary to make institutions safer for children:

- Commitment to child protection
- Clear definitions of good practice
- Open environment
- Close contact with families, communities and disabled adults
- Respect for ethnicity, religion and the individual
- High internal awareness to abuse[113]

Paul et al (2004) undertook an examination of child protection policies and practice in UK coeducational residential special schools for children with severe and multiple physical and learning disabilities. The aim of the project was to identify and describe good practice models for child welfare and protection. These were to be incorporated into practice guidelines to be made available for management, staff training and practice development. Findings were also intended to be used in a guide to inform parents on standards of child protection safeguards they should be able to expect while their children are at a residential school[114]. They found that schools with high awareness and good practice had explicit whistle-blowing procedures, combined with an open 'no blame' culture and good staff support. Where there was a more rigid, hierarchical approach, they said, poor practice could be found[115].

Paul et al (2004) also noted that:

> Many pupils in the [special] schools exhibited very challenging behaviour. Schools which specialised in providing for these children showed expertise and good practice, having understanding of the causes and triggers for difficult behaviour, with individual behaviour management plans, agreed with appropriate specialist advice, ratified by senior staff, and well communicated between all staff working with the child. Schools where few children displayed such behaviour were much less well prepared[116].

They concluded that results from their study strongly endorse conclusions from many public enquiries into residential services that 'close involvement of senior managers in day to day care, with strong leadership and support, are the best safeguards for good practice[117]'.

Bowman et al (2010) noted that the largest group of identified perpetrators of sexual abuse of people with developmental disabilities is developmental disability service providers. They developed, implemented, and evaluated the effectiveness of a sexual abuse prevention training programme for disability service staff. Participants were administered a survey assessing knowledge and attitudes before and after the training workshop. Small improvements in knowledge and attitudes about sexual abuse and the sexuality of persons with developmental disabilities were found; however, they report, general attitudes about individuals with developmental disabilities did

[112] Cross, M., Gordon, R., Kennedy, M., and Marchant, R., (1993). NSPCC, Way Ahead Disability Consultancy, National Deaf Children's Society, and Chailey Heritage Child Protection Working Group. *The ABCD Pack: Abuse and children who are disabled*. ABCD Consortium: Leicester.
[113] Marchant, R. and Cross, M. (1993). Places of safety? institutions, disabled children and abuse. In: *The ABCD Pack: Abuse and Children who are Disabled*. The ABCD Consortium. Leicester UK: NSPCC.
[114] Paul, et al (2004).
[115] Ibid, p 8.
[116] Ibid, p 9.
[117] Ibid, p 9.

not change[118].

Barron and Topping (2010) studied the effectiveness of school-based child sexual abuse prevention programmes and the implications for the effective delivery of such programmes. Findings included:

- Evidence of a high level of prior knowledge of abuse prevention concepts among students.
- Reporting of emotional gains for students who participated in abuse prevention programmes.
- Higher levels of disclosure among students who had participated in programmes.

Barron and Topping's recommendations for effective programmes include:

- Involving parents,
- Assessing children's prior knowledge,
- Training for teachers that takes their attitudes into account and enables them to notice, and respond appropriately to disclosures[119].

The Irish National Disability Authority has described the key stages of intervention as:

- Prevention
- Identification and disclosure
- Referral on to appropriate agencies
- Preventing recurrence of abuse
- Treating individuals who have been abused
- Helping victims to recover
- Detection, prosecution, punishment and compensation[120]

Paul et al (2004) interviewed managers, staff and parents to evaluate child protection policies and practices at 11 coeducational residential special schools for children with severe learning difficulties in the UK. The project covered emotional, physical and sexual abuse and neglect, as well as system abuse such as inappropriate treatment approaches. From this information they explored ways in which schools can deal with risks and developed best practice guidelines. They found a notable degree of commitment to and concern about the progress, happiness and safety of the students in all schools: 'Staff were continuously grappling with the need to find a balance between ensuring children's safety and giving them a flexible and stimulating environment[121]'.

They identified the important issues that emerged as those connected with child protection awareness and procedures, staff training, communication with children, the management of children and adolescents' sexuality and need for affection, and behaviour management. Practices they observed are described below:

CHILD PROTECTION AWARENESS

Schools with high awareness and good practice had explicit whistle-blowing procedures, combined with an open 'no blame' culture and good staff support. Staff knew to which members of the senior team they should go with any concerns, and they knew the names of external contacts if they felt unable to raise the matter within the school. There was a clear reporting procedure and specific

[118] Bowman, R. A., Scotti, J. R., and Morris, T. L. (2010). Sexual abuse prevention: A training program for developmental disabilities service providers. *Journal of Child Sexual Abuse, 19*(2), 119-127.

[119] Barron and Topping (2010)
[120] Irish National Disability Authority website.
[121] Paul et al (2004), p 109

record keeping.

In schools where practice had more problems, there were often poorer communications generally, and the same procedure was used for reporting child protection incidents and other less serious matters. Where there was a more rigid, hierarchical approach, poor practice could be found. Recording and reporting practice varied considerably within and across schools. Schools differed in the amount of help they received from their local authorities in developing child protection procedures, and there were some grey areas concerning informal enquiries to be made before a formal investigation, with which it could be difficult to deal.

TRAINING

All schools offered in-service training and most staff felt that they had generally good training opportunities, but availability of external training varied, and appropriate specialist training for child protection and related topics, suitable for children with severe and multiple disabilities, was rarely available. Schools provided by larger organisations appeared to have better training opportunities that those operating in isolation. It was particularly difficult for schools to provide training in an area where they had relatively few pupils with a particular need. This impacted markedly on schools which had small numbers of children with very challenging behaviour. They found it difficult to provide appropriate training for all staff in managing such behaviour.

COMMUNICATION

Staff used a range of imaginative approaches to communication and most worked hard to ensure that they could understand the individual ways that children communicated, and to help them make choices and enjoy school. Many examples of good practice were found in all schools, and staff had developed a wide variety of means of communication with children who had limited or no speech Where poorer practice was found, this was usually connected with poor training and monitoring by managers. Some examples of very poor practice (for example staff ignoring children, talking across children, or discussing their behaviour and personal details in front of other children) were also found.

AFFECTION AND SEXUALITY

This was the area that schools found most difficult, with both guidance and practice varying considerably within and between schools. Staff often felt ill prepared. They sometimes ignored their own schools' guidance on showing physical affection, because it seemed to them at variance with common sense, or to deny children's need for affectionate touch, when they are away from home and may spend most of the year at school.

On the other hand, in several schools little guidance was available to deal with children's developing sexuality, especially with the older adolescents, leading to age-inappropriate behaviour which made both students and staff vulnerable. The schools' difficulties reflected wider issues about dealing with the sexuality of people with learning disabilities, and few schools had clear plans for sex education for students.

BEHAVIOUR MANAGEMENT

Many pupils in the schools exhibited very challenging behaviour. Staff needed considerable patience and self-control to work in some of these situations, and it was common for staff to be physically hurt by pupils, and to have to deal with aggression. Schools which specialised in providing for these children showed expertise and good practice, having understanding of the causes and triggers for difficult behaviour, with individual behaviour management plans, agreed with appropriate specialist advice, ratified by senior staff, and well communicated between all staff working with the child. They provided good support and training for staff.

Schools where few children displayed such behaviour were much less well prepared, and there were some worrying examples of poor practice, especially in the use of physical restraint. There were some specific issues over the use of medical restraints to prevent self-injury which caused distress to children and staff.

HANDS ON MANAGEMENT AND EXTERNAL SUPPORT

Results from this research strongly endorse the conclusions from the many recent public enquiries and research into residential services, that close involvement of senior managers in day to day care, with strong leadership and support, are the best safeguards for good practice. In schools with good practice, senior staff were visibly present in the classrooms and residential units, and made their presence felt without undermining the autonomy and professional skills of their staff. Seniors were deeply involved in approving and monitoring plans for individual children, and in monitoring practice in dealing with challenging behaviour, child protection concerns and other problems.

External support from community child protection and training services is also important but provision of both were much more variable, and this is one of the major issues for the development of adequate safeguard for children away from home. The need for support was not simply to deal with possible poor or abusive practice by staff, but in working with problems arising between pupils or with concerns about children's safety when off the school premises, including periods at home with their parents. Many of the most worrying incidents described concerned external services' reluctance to consider the possibility that children had been abused at home, or to take seriously evidence of abuse from children's accounts, behaviour or injuries. There was too often an assumption on the part of external professionals that behaviour reflected the child's disability, or that no case could be pursued because the children would not be able to give evidence. Schools felt that their knowledge of the children, and of the meaning of the children's behaviours, was often discounted and that abuse of a disabled child was responded to quite differently from that of any other child.

LIAISON WITH PARENTS.

Many schools had large catchment areas which meant that children were a long way from home. The schools developed an impressive array of methods to keep children in contact with parents, but there were still some areas of great uncertainty about issues such as when to inform parents about possible difficulties with children, or when school staff and parents had different views on what was best for children. The importance of local placement facilitating regular face to face contact was highlighted by these difficulties, and has implications for the way that the provision of special schools operates. The great importance of adequate information for parents about a school's regime and programme, and about how to take up any concerns and complaints, was also evident.
In the best situations, contact was two-way, with school staff able to visit children at home and spend time supporting parents as well as the parents visiting the schools. Schools in their turn recorded the problems which occurred when families received little or no support from local services with their very needy and sometimes challenging children during the long school holidays[122].

Paul et al (2004) conclude by saying good practice in the protection of disabled children in residential settings requires:

- Suitably trained staff with supervision and accountability
- A positive child oriented ethos promoting consistent communication development
- Consultation with children and provision of choice
- Child/disability specific guidelines for behaviour management

[122] Paul, et al (2004)

- Medical and therapeutic intervention and personal care; and
- Comprehensive integrated education and social care plans involving parents, staff and pupils[123].

Conclusion

In this review of the safety of coeducational special residential schools a myriad of observations and recommendations arise. The appalling prevalence of abuse (of any type) perpetrated toward people with intellectual disabilities and/or behavioural and conduct disorders (including emotional disorders) in contrast to their non-disabled peers should be heeded both as in indictment of the inability of society to safeguard this already vulnerable group of people and as an underlying precursor to ongoing issues for these young people as both victims and potentially, as perpetrators, of abuse. Young people appearing in out-of-home placements are more often already the victims of abuse and the on-going abuse noted in these settings internationally is of real concern.

The provision of residential special schools in New Zealand are a last resort option for young people whose educational and behavioural needs are such that all other options have failed. Bringing together this unique group of students in locations frequently isolated from family/whanau presents safety concerns that are reflected in international research. However, the literature also points to policies and practices that can increase vigilance within these settings and develop a body of front line staff and specialists that are, well trained professional, self-reflective, consistent, fair and fun to be around.

Safety can be maximised but only with continual vigilance both internally and externally. External vigilance will not only involve official reviews but also the involvement of family/whanau/caregivers, external professionals and community groups who are associated with each student. Schools or residential accommodation should avoid being isolated from community and family.

Internal vigilance will involve all stakeholders, including the Board of Trustees, associated professionals and government agencies, senior management teams, teachers, residential staff, support staff and students. Appropriate and detailed policies and procedures, clear recruitment guidelines and vetting procedures, a team based culture that allows for frank and open discussion, good professional supervision, a sufficient pool of staff and low student to staff ratios, the development of a positive culture both in terms of attitudes toward students and other staff, and ongoing and relevant professional training. The recommendations/observations of best practice from the United Kingdom are also strongly supported by these reviewers.

Breaking the cycle of abuse between peers is also suggested in the literature and themes emerge of the need for;

- boundaries (and rules) that are fair, consistent and relevant,
- providing appropriate education in personal safety, bullying, and sexuality (including sexual abuse),
- providing avenues for disclosure that take people seriously,
- using appropriate behaviour support plans (including functional behaviour assessments),
- providing functional environments that allow for privacy,
- creating trusting relationships with key staff and staff generally,
- providing continual supervision 24/7.

[123] ibid, p 19.

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