'Stop!, I don't like it!' An evaluation of the 'Healthy Relationships' programme.

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1 Acknowledgements

The evaluation team would like to thank the managers and staff of the schools for participating in the evaluation; and for their hospitality, honesty and openness during the site visits.

A special thanks also to the parents and caregivers who gave of their time so freely to discuss personal and sensitive issues so willingly.

“One hundred percent improved in some way, all our kids, in fact the whole lot, have improved because they now all say ‘no’. Before people would have been over-compliant and they would have said 'yes' to everything in the world”

Teacher

2 What is 'Healthy Relationships'?

'Healthy Relationships' is a programme designed by Kidpower Teenpower Fullpower Trust to teach personal safety through explanations and interactive stories .The goal of the stories is to develop understanding of the four rules of a 'Healthy Relationship', and allow the skills to be rehearsed in a group or as an individual, using the following resources:

CD: The CD contains interactive activities or stories for students, that allow them to learn skills with their friends, using a very basic 'point and click' interface.

Booklets: The booklets contain the exact same scenario as the CD. This allows them to be practiced without computer access.

Sticker Pages: To encourage students in their progress.

Poster: Designed to help facilitators go through the role plays with the student/young person.

Clarity Research Ltd has been commissioned by Kidpower Teenpower Fullpower Trust to evaluate Stage I of the 'Healthy Relationships' programme in two schools.

3 The literature

It is widely acknowledged that Aotearoa New Zealand has very little research and evaluation available in our knowledge economy that deals directly with the Aotearoa New Zealand context. Many evaluation authors put this down to the change to Aotearoa New Zealand markets in the early 1980's, early 1990's and late 1990's (Cheyne et. al. 2005, Lunt et. al. 2003). As such it should not be at all surprising that Clarity Research's evaluation and library staff were unable to find a great deal of local content in relation to the subject of evaluation. As such Clarity has sourced information from both Aotearoa New Zealand and other countries.

3.1.1 The literature review process

The literature review process began with a thorough search of peer-reviewed journals for articles related to youth with intellectual disabilities. We used the following databases: Medline, PsycINFO, Cochrane Library, CINAHL, ERIC, PubMed, and ISI Citation Databases (Web of Science). Clarity Research consulted with librarians to ensure that our literature search efforts would locate all relevant publications. We used an electronic library to manage the research, which enabled us to effectively manage the results. Search terms included: /developmental disabilities/ or /cognitive/ or /mental retardation/ or /intellectual disabilities /and /sexual abuse/ or /sexual assault/ or /abuse/ and /prevention/ or /support/ or /education /or /programme or /programmes/. These terms were applied, and then all possible variations were entered to exhaust the search. When relevant articles were identified, their cited references were searched to locate other possible articles. Internet searches using the same terms were conducted to provide background information. Key author bibliographies were also searched for relevant articles.

3.1.2 Introduction

Along with increased opportunities with greater social inclusion have come increased instances of exploitation and abuse for people with intellectual disabilities. Studies consistently demonstrate that people with intellectual disabilities are sexually victimised more often than others who do not have a disability (Briggs, 2006) (Davis, 2005); (Furey, 1994).

There is growing recognition that children, adolescents, and adults with intellectual disabilities are particularly vulnerable to sexual abuse and exploitation and are in need of intervention services. These people are especially vulnerable due to their often life-long dependence on caregivers, relatively powerless position in society, emotional and social insecurities, and lack of education regarding sexuality and sexual abuse (Tharinger, Horton, & Millea, 1990).

More than 90 percent of people with developmental disabilities will experience sexual abuse at some point in their lives and 49 percent will experience 10 or more abusive incidents (Valenti-Hein & Schwartz, 1995). Other studies suggest that 39 to 68 percent of girls and 16 to 30 percent of boys will be sexually abused before their eighteenth birthday (cited in (Davis, 2005)). Only three percent of sexual abuse cases involving people with developmental disabilities will ever be reported (Valenti-Hein & Schwartz, 1995).

People with intellectual disabilities often do not realise that sexual abuse is abusive, nor do they know it is illegal. Similarly, they may not be aware that abuse generally is not to be tolerated. Consequently, they may never tell anyone about abusive situations. It may be even more difficult for people with intellectual disabilities to report abuse because they commonly learn not to question caregivers or others in authority. Unfortunately, these authority figures are often the ones perpetrating the abuse.

People with intellectual disabilities are rarely educated about sexuality issues or given self-assertiveness training, which is necessary in learning the difference between “safe” versus “unsafe” people and situations, and in knowing how to say “no” to unwanted sexual propositions or mistreatment (Davis, 2005). They often think they do not have a right to refuse abusive treatment, especially if the abuser is an authority figure or someone known to them, such as a parent, step-parent, relative, teacher, caseworker, member of the clergy or some other individual who is well-respected by other family members, neighbours or peers (Davis, 2005).

3.1.2.1 Factors associated with abuse in those with intellectual disabilities

Numerous factors are associated with sexual assault generally, including prior victimisation, the victim’s abuse of substances, non-assertive behaviour, low socioeconomic status, acquaintance with the perpetrator, and lack of knowledge of risk factors (Yeater & O'Donohue, 1999). These issues are all present in those with intellectual disabilities. Several sexual violence researchers have argued that self-defence prevention programmes directed at women are more aptly named deterrence programmes, for they do not actually prevent sexual violence but deflect the perpetrator away from one victim and toward another, and often more vulnerable, target (Barger, Wacker, Macy, & Parish, 2009).

Some of the reasons put forward for the high rates of sexual abuse are that people with intellectual disabilities are less likely to receive any form of sexual education in school or elsewhere (Carmody, 2006), including training on assertiveness, healthy relationships, proper feel and touch, or warning signs of sexual abuse (Kempton & Kahn, 1991).

People with intellectual disabilities are often socialised to be compliant, are more likely to live in poverty, and remain substantially more dependent on caregivers than non-disabled (Wacker, Parish, & Macy, 2008). Additional factors may include deficits in communication, an inability to seek help or report abuse, lack of knowledge on how to defend against abuse, and lack of education regarding appropriate sexual behaviour (Sobsey & Varnhagen, 1988); (Lumley, Miltenberger, Long, Rapp, & Roberts, 1998).

Perpetrators are likely to target the most vulnerable and easily manipulated to whom they have access, those who they believe will not report, and those who are socially isolated (Carlson, 1997). In the general youth disability literature, there has been a growing number of accounts of disabled young people being targeted by sexual predators specifically because they either cannot report the abuse or will not be believed when such abuse is reported (Groce, 2003).

One study of 461 cases of sexual abuse of adults with intellectual disabilities found that the majority of the perpetrators are men (88%) and included other adults with intellectual disabilities, paid staff, family members, and others. Of great concern, most sexual abuse occurred in the victim's residence, and in 92% of the cases the victim knew his or her abuser (Furey, 1994).

Watson has suggested that deficits in judgment and social skills may result in an increased vulnerability to sexual abuse (Watson, 1984).The specific reasons why people with intellectual disabilities often fail to make good decisions is not well understood. Rather than just cognitive factors determining decision making, motivation and emotional factors are also involved. Until recently the literature on the prevention of abuse in intellectual disabilities has focussed on cognitive factors. This changed with the work of Khemka, who showed that while both approaches were effective relative to a control condition, the combined cognitive and motivational training approach was superior to the cognitive only training approach in improving decision making by those with intellectual disabilities in abusive situations (Khemka, 2000)

3.1.2.2 Previous programmes developed to Prevent Abuse

Although sexual abuse is a significant problem for people with intellectual disabilities there is little research evaluating prevention programmes for this population (Haseltine & Miltenberger, 1990); (Llewellyn & McLaughlin); (Lumley, et al., 1998); (Miltenberger, et al., 1999); (Bowen, 2000); (Johnson, Frawley, Hillier, & Harrison, 2002); (Hickson & Khemka, 2001); (Khemka, 2000); (Khemka, Hickson, & Reynolds, 2005).

Barger and colleagues (Barger, et al., 2009) have reviewed the literature on programmes that had a focus on reducing sexual assault specifically against women with intellectual disabilities. Only three studies could be found of use to this review, that evaluated prevention programmes for women with intellectual disabilities (Bowen, 2000); (Johnson, et al., 2002); (Hickson & Khemka, 2001); (Khemka, 2000); (Khemka, et al., 2005).

3.1.2.3 Taking Care of Me (Bowen, 2000)

'Taking Care of Me' integrated a variety of resources and provided recommendations for the development of future interventions. Specifically, Bowen posited that a curriculum intended to prevent the sexual assault of women with intellectual disabilities must serve as part of a comprehensive programme that includes themes of assertiveness, social skills, relationships, and self-confidence training. However, evaluation of this programme consisted of a participant satisfaction survey.

3.1.2.4 Living Safer Lives (Johnson, et al., 2002)

The intervention consisted of a six week workshop, initially piloted with 38 women with intellectual disabilities, during which previously developed narratives served as the basis for discussion about safe and fulfilling sexual relationships as well as assault prevention. Details about the workshop procedures or activities were not reported. Evaluation of this programme, again, consisted of a participant satisfaction survey.

3.1.2.5 An Effective Strategy-Based Curriculum for Abuse Prevention and Empowerment" (ESCAPE). (Khemka, et al., 2005)

To the best of our knowledge, this is the only published RCT to compare decision making strategies to enhance decision making skills of individuals with intellectual disabilities in interpersonal situations involving abuse. Khemka and colleagues built upon the earlier success in improving decision-making training (Khemka, 2000). This framework was divided into four parts: framing the problem, generating alternatives, evaluating anticipated consequences of possible alternatives, and choosing a course of action.

A pretest–posttest control group design was used to compare effects of two training conditions and a control condition (decision-making training, self-directed decision-making training, and no training) on independent decision making performance of women with intellectual disabilities. Participants in the self-directed decision-making training group provided more independent decision-making responses than did those in the decision-making training or control group (with little difference between the latter two groups on decision making scores).

While this remains the best study available on the prevention of abuse in women with intellectual disabilities, there are a number of limitations (Barger, et al., 2009); including:

- Small sample size (only 12 individuals in each arm of the study)
- Screening of individuals with communication difficulties limits the applicability of findings to persons with more severe intellectual disabilities, who are likely the most vulnerable and most in need of effective intervention efforts.
- Some factors that would likely influence the effectiveness of an individual's response to an abusive situation were not addressed, including level of physical dependence on others, communication difficulties, ability to cope with extreme stress.
- Although women in the intervention group showed significantly more decision-making skills in simulated abuse situations, their level of ability (as measured by production of effective responses only 58% of the time) implied a skill level well below mastery
- As with other studies, this project did not address the challenges that women with intellectual disabilities face when victimised by someone they know, trust, or depend for their care needs.
- The intervention did not evaluate whether the programme actually reduced sexual assault victimisation.

These limitations are instructive when examining all literature in this area and developing any evaluation of a similar service. Despite these limitations, the curriculum recognised and addressed the vulnerability of individuals with intellectual disabilities to various forms of abuse, finding its origin in a lack of empowerment, learned helplessness, and support systems that teach compliance.

Findings of ESCAPE suggested that the ability of an individual with intellectual disabilities to make an effective decision against abuse not only related to cognitive strategies being available but to factors related to self-motivation (establishing greater self-confidence, motivation to act, sense of

empowerment).

3.1.2.6 What factors impact on the success of Prevention programmes?

Problem-prevention efforts generally for young people are most beneficial when they are coordinated with explicit attempts to enhance their competence, connections to others, and contributions to their community (Eccles & Appleton, 2002). Key strategies that characterise effective school-based prevention programming involve the following student-focused, relationship-oriented, and classroom and school-level organisational changes (Greenberg, et al., 2003):

(a) teaching children to apply social, emotional, and academic learning (SEL) skills and ethical values in daily life through interactive classroom instruction and providing frequent opportunities for student self-direction, participation, and school or community service;

(b) fostering respectful, supportive relationships among students, school staff, and parents; and

(c) supporting and rewarding positive social, health, and academic behaviour through systematic school–family–community approaches.

In most cases short-term preventive interventions produce short-lived results. Conversely, multiyear, multi-component programmes are more likely to foster enduring benefits (Greenberg, et al., 2003).

In order to protect themselves against abuse and victimisation, individuals with intellectual disabilities must have the skills to independently recognise a potentially abusive situation and respond appropriately (Lumley, et al., 1998). Incidents involving abuse are often associated with decision-making opportunities in which the potential victim may be able to take action to avoid or escape from the situation. Therefore, decision- making skills that involve the ability to perceive the potential for harm, generate possible alternative courses of action, weigh the relative risks and benefits of each course of action, and choose a suitable course of action appear critical to the successful handling of an abusive situation (Khemka, et al., 2005).

However, research has shown that decision-making is an area of particular difficulty for people with intellectual disabilities (Hickson & Khemka, 2001). In order to address this issue, it is necessary to examine the decision-making skills of people with mental retardation in a range of situations involving interpersonal conflict and abuse.

Several factors are associated with the increased likelihood of uptake of abuse prevention programmes. More specifically, in those with intellectual disabilities, abuse prevention programmes tend to consist of instructions, modeling, rehearsal, feedback, and praise (Haseltine & Miltenberger, 1990) along, more recently, with *in situ* training[1] (Egemo-Helm, et al., 2007).

1 *In situ* training consists of a realistic situation using a confederate. The confederate approaches the participant at a pre-determined location (e.g., park or front yard) and presents an abduction lure or other inappropriate behaviour. If the subject fails to demonstrate the appropriate safety response, the trainer then appears and implements training. This consists of providing instruction and modelling, and engaging the participant in rehearsal of the skills in a role-play while providing praise and corrective feedback, as needed. *In situ* assessments, are where a sexual abuse lure is presented without the participant's knowledge that they are being tested and the participant's responses are assessed.

Khemka and Hickson (2000) investigated the ability of men and women with mental retardation to suggest self-protective decisions in response to simulated situations of abuse. Simulated instructional experiences have a number of practical advantages in abuse prevention programmes. These include: a.) greater opportunity for repeated testing and training during a session, b.) reduced cost, c.) less risk of danger, d.) less stigmatisation of unskilled students in public settings, and e.) less disruption to school scheduling (Bates, Cuvo, Minera, & Korabeka, 2001). However, when simulations are used, teachers often "train and hope" that students will be able to perform the targeted skills in community environments (Bates, et al., 2001).

Theoretically, generalisation of simulation-based learning should occur to the degree that simulations adequately represent the stimulus and response variability associated with community (Bates & Cuvo, 1984). However, uptake and transfer of learned skills depends very heavily on the degree of intellectual disabilities, with the more severely disabled unable to generalise (Bates, et al., 2001). Previous research has shown that behavioural skills training to teach sexual abuse prevention skills to people with intellectual disabilities results in skill acquisition but poor generalisation (Miltenberger, et al., 1999).

The principal advantage of more naturalistic (or *in situ*) instructional arrangements, such as community-based settings and natural materials, is that students are taught to respond to the actual stimuli, thereby mitigating problems associated with the transfer of stimulus control from simulated conditions.

A significant limitation of early *in situ* studies was that role-plays of abduction situations were used for assessment but the participants' responses to sexual abuse situations involving familiar persons were not assessed. This issue is a limitation because sexual abuse perpetrators are most often known to the victims[2]. Lumley and colleagues (1998) attempted to remedy this short-coming of previous programmes. The target behaviours were to say no, leave the situation/perpetrator, and report the incident to a trusted adult when a solicitation for sexual activity was delivered by a confederate portraying a staff member. The integration of well-planned simulated instruction with community-based training experiences has been suggested by some researchers to represent the best arrangement for teaching many with intellectual disabilities (Bates, et al., 2001).

3.1.3 Summary

Barger and colleagues (2009) have looked at the requirements of effective programmes and suggested that a systemic approach would be required that would need to incorporate a host of concerns, including the reliance of those with intellectual disabilities on care providers and family, limited material resources, and limited communication abilities. Morrissey, et al., (1997) have developed a set of evidence-based criteria for effective programmes, all of which may be applied to the prevention of abuse against those with intellectual disabilities. Effective programmes should be:

- *Comprehensive*. The programme should involve all the systems that have a direct impact on the participants. For those with intellectual disabilities, this may include family, friends, partners, caretakers, case workers, therapists, or employment support professionals.

- *Theoretically based*. The programme should be based on a clear theoretical model that explains the problem of abuse against those with intellectual disabilities. Applying a theoretical foundation encourages consistency throughout all aspects of the programme.

2 Up to 99% of the time the abuse is perpetrated by friends, relatives, and caretakers of the person with developmental disabilities (Fisher & Field, 1985).

- *Intensive*. The programme should offer sufficient contact between the trainer and participants. For participants with intellectual disabilities, short and frequent sessions that use a variety of teaching methods may prove most effective.

- *Tailored to the needs of the participants*. The programme should account for participants' age, communication abilities, care needs, cognitive functioning, and developmental level. The material should be intellectually appropriate and flexible enough to accommodate the varying communication and learning needs of the participants.

- *Focused on skill development*. The programme's curriculum should be active and provide hands-on experiences to increase participants' skill level. The programme should offer practical and feasible tools that are relevant to real life for those with intellectual disabilities.

- *Sufficient follow-up*. In general, the positive effects of prevention programmes wane over time without appropriate follow up. Participants with intellectual disabilities may need to attend ''booster'' sessions.

- *Evaluated*. The programme is continuously evaluated.

- *Have consumer ownership*. The people for whom the programme is intended (those with intellectual disabilities) should be involved in all levels of the programme development, including planning, implementation, evaluation, and advisory boards.

Similarly, a UNICEF study (1999) providing an overview of young people living with disabilities generally, identified that programmes acknowledged as successful seem to share a set of common attributes. Whether serving young people with disabilities separately from, or alongside with, their non-disabled peers, such programmes:

1. Encourage them to engage in activities that build the skills and confidence they will need to function effectively in society.

2. These programmes have well thought out outcomes, sufficient organisation structure and funding for on-going support.

3. They include an evaluative component to ensure that programmes and services provided meet the actual needs of young people as well as their long-term goals.

4. Finally, such programmes were felt to be particularly effective when young people with disabilities themselves help design, oversee and evaluate them.

These recommendations serve to place the Kidpower Teenpower Fullpower Trust on sound theoretical ground in terms of the underpinnings of the 'Healthy Relationships' programme, as many, if not all of these recommendations may be seen in the development of the programme.

4 Method

4.1 Examination of quantitative data

There was a limited parent survey conducted prior to commencement by Kidpower Teenpower

Fullpower Trust. Prior to the commencement of the 'Healthy Relationships' programme, a questionnaire was disseminated among parents/caregivers of teens with intellectual disabilities at the non-residential school. Twelve parents/caregivers completed the questionnaire. These questionnaires were primarily designed to ascertain where specific problems were arising in terms of physical boundaries – both those from the young person, and towards them - in order to gauge what levels of information parents/caregivers had along with areas where information/knowledge was lacking. The parent's questionnaire specifically focussed on what issues and needs parents had about the risks their children faced from sexual abuse from others.

A quantitative pre-post survey of students'/young people's behaviours was sent out to parents and teachers by Kidpower Teenpower Fullpower Trust before Clarity Research were engaged for this evaluation. Unfortunately no surveys were returned from the post- intervention mail-out and therefore quantitative information was not included in the present evaluation.

4.2 Qualitative Interviewing

Qualitative interviewing is a process of gathering data using a conversation. During this conversation data is gathered inductively as participants describe in detail the ecology that describes a programme and it's influence on their social world.

4.3 Qualitative Data Analysis

The analytical techniques used to determine the outcomes determined in this evaluation are determined by the kind of data collected (i.e., qualitative rather than quantitative; illustrative rather than representative; and rich textured insights instead of closed-ended responses). This means the analysis presented here has been built around the following three part structure:

1. Themes (elements of the 'story' running through the data);
2. Exemplars (examples that highlight these themes); and
3. 'Zingers' (quotes which captured the essence of the theme well)

The integrity of the analysis was underpinned by a technique known as 'triangulation'. This is a common technique for establishing the veracity of data gathered in qualitative research projects, and involves the use of multiple sources of information, and perspectives. This mix enables the researcher to 'see' the research question from a number of different perspectives and therefore, to have much more confidence that the findings are accurate[3].

4.4 Report Format

This report is presented in a basic 'office' format for two key reasons:

1. Clarity Research's evaluation staff have found that this enables public relations, printing company, and other staff to change the layout and other points with ease enabling a fast turnaround for clients who require 'direct to public' or 'direct to institution' information dissemination.
2. The simple format lends itself to the removal of bias in the reader by ensuring that information is presented in a format that is simple and yet structured.

This report also has a typical breakdown of participants, ethics, and general findings. Role specific findings have been added to enable a context-specific elaboration of the 'Healthy Relationships' programme. Readers should expect to see the activities involved with, and perspectives of, the

3See Tolich, M. and Davidson, C. (1999) Starting Fieldwork: An Introduction to Qualitative Research in New Zealand. Oxford University Press. Auckland.

programme at the time the data was gathered for the evaluation.

4.5 Evaluation participants

There were four key groups who chose to participate in this evaluation (see. Table 1). Interviews were conducted with caregivers, teachers, teacher aids, and residential staff. These groups presented very similar perspectives of the programme in successive transcripts. Kidpower Teenpower Fullpower Trust identified, contacted, and arranged meetings with stakeholders and clients on behalf of the evaluation team.

4.5.1 Table 1: Groups Interviewed

Teachers and Teaching Management	Residential Care Workers and associated managerial staff	Teacher Aides	Parents
Two teachers from a residential school who were currently using the 'Healthy Relationships' programme	Three residential social workers/caregivers who worked with young people after hours in a residential school setting	Teacher aids who worked with young people and teachers in a series of classrooms devoted to special education within a non-residential schooling environment.	Four parents whose child attended a school that had a series of classrooms devoted to special education within a non-residential schooling environment.
Two teachers from a school that had a series of classrooms devoted to special education	One manager of a residential facility who had experience working with young people in residence.		
One manager of a special education unit			

4.5.2 Who were Teachers and Teaching Management?

Teacher and Teaching Management who took part in this evaluation had, on average, more than 10 years experience in their field and were specialists in teaching children with intellectual disabilities, behavioural issues, and scholastic impairment.

All Teachers who participated in this evaluation were quick to describe their role as one that attempts to impart their students with knowledge despite the intellectual disabilities and behavioural issues that arose with this group.

“I am in special education. I teach students with intellectual disability and behavioural issues”

Teachers who participated in this evaluation highlighted their role in improving the social skills of the students in their classes and their task in role modelling and role play in terms of appropriate behaviour where possible.

“My role is to improve social skills... some students have very little role modelling. Social skills role modelling. Other students have difficulty interpreting social gestures. It is for this reason we must consistently role model.”

As a result, Teachers had to customise the programme to fit into the classroom environment. Consequently, both Teachers and Teaching Management were very familiar with the 'Healthy Relationships' programme, the programmes roll-out in their schools, the level of co-operation with Kidpower Teenpower Fullpower Trust, and had many examples of the programme outcomes including concrete examples of where students used the programme to ensure a 'Healthy Relationship' and prevent sexual predation; and develop expression.

4.5.3 Who were residential care workers and their managerial staff?

Residential staff and their manager were interviewed in a group setting due to time constraints and participant request. Prior to the interview, evaluators and analysts had discussed whether this was the appropriate method for representing participant data with the client, residential staff, and teaching staff. All parties agreed that this was the only way that information could be gained in the evaluation time-frame available, considering the workload of the participants.

Residential care workers and their management had a role in tutoring young females with developmental and scholastic delay. They were responsible for pastoral care, life skills, and social skills. Residential Care Workers played an intensive care role regarding the behaviour of students in residence. They were quick to use consequences and incentives to correct behaviour and enable learning. They described that the chosen behavioural modification methods were based on their social work training and practice experience.

"*There is nothing more harmful we can do to our girls then to NOT advise them that their behaviour is not okay*"

As such, residential care workers had valuable practice experience with young people who participated in the programme. Residential care workers who were interviewed as part of this evaluation experienced teaching the programme, homework activities associated with the programme, and day to day interactions with the students who were learning the 'Healthy Relationships' programme.

The initial interview process with Residential Care Workers and associated managerial staff provided the evaluators with valuable insight into the workings of the Kidpower Teenpower Fullpower Trust's 'Healthy Relationships' programme. Residential Care Workers and associated managerial staff have commended the programme based on observation and experience.
Information provided by Residential Care Workers and associated managerial staff, not only provided Kidpower Teenpower Fullpower Trust with solid practice experience, their information also posed significant questions for Kidpower Teenpower Fullpower Trust on which to base future directions for the programme.

4.5.4 Who were Teacher Aides?

Teacher Aides described themselves as working 'in the moment' under the clear and direct instruction of the teaching staff with very little need to know why they were asked to do something:

"I am a Teacher Aide. I give Support where needed."

"I get no information, I just get told what to do."

As such, information from Teacher Aides was not as in-depth as other groups in the sample. Teacher Aides did notice changes in behaviour and benefits from the 'Healthy Relationships'

programme; including a change in expressive language. Moreover, Teacher Aides were quick to point out that not everyone will understand, or express that they have understood, the content of the 'Healthy Relationships' programme.

Despite this, Teacher Aides have described real change in all of the students they work with as a result of the 'Healthy Relationships' programme.

4.5.5 Who were parents and caregivers?

Parents and caregivers provided evaluation staff with a complex perspective that displayed the link between the lifestyle of the parent and capacity of young people in their care to interact with programmes and the greater social world.

Evaluation staff combined information from both parents and caregivers as the information in all transcripts were remarkably similar with very little subtle difference.

Parents and caregivers described their roles as being the organiser and provider in the day to day lives of the children in their care.

"What ever [name] *needs, I will try my best to do it for* [gender]*, without me* [gender] *couldn't do life"*

Parents and caregivers who participated in the evaluation of the 'Healthy Relationships' programme described themselves as suffering from **parent or carer fatigue**. Parents stated that this phenomenon prevented them from being fully aware and involved in their child's lives in a majority of cases.

"The parents of the students at the age of 19 or 20 have fatigue. At this stage most parents need a break. Someone should research this."

Parent or carer fatigue was described by both carers and parents as the same list of symptoms:

"constantly exhausted"

"tired all the time"

"information overload"

Parents and caregivers who participated in this evaluation described being in a state beyond the point of information overload, and experiencing mental and physical exhaustion. Despite this, some parents were involved in the day-to-day lives of their children and some were unable to be involved.

"Some parents, like me, acknowledge parental fatigue, but carry on regardless"

"It's hard work!, I mean more mentally demanding, trying to work out how to get [gender] *up to independent and how to get through to* [gender]*, you need a lot of patience,* [gender] *thinking is very slow. Even physically* [gender] *is a bit slow."*

In addition to this, parents were ill-informed on an individual basis about the detailed nature of the 'Healthy Relationships' programme.

"My [gender] *doesn't really bring anything back but* [gender] *said we had Teenpower today."*

As such, parents and caregivers were unable to describe programme activities and outcomes in any depth. Moreover, parents and caregivers who experienced the programme when invited into the school environment by Kidpower Teenpower Fullpower Trust stated that what they saw was of a high standard and that they were more than happy for their child to learn the four questions of the 'Healthy Relationships' programme independently. To this end, the exhausted parents and caregivers were not keen to be involved beyond the point of the initial invitation and would have preferred to be informed by another method; usually e-mail, direct mail, or telephone.

4.6 Evaluation ethics: Ensuring participants understood

Evaluation participants volunteered their time and understood the limitations of the anonymity and confidentiality of the data they provided during the consent process. A considerable effort was undertaken by evaluation staff to ensure participants demonstrated an understanding of the ethical requirements of evaluators in relation to the confidentiality and anonymity of any data provided during the evaluation. This effort also extended to explaining the exact nature of how participant data would be used; including anonymising quotes and publication of a report of findings. In order to be as sure as possible that participants could not be recognised from any quotes used in this report, the gender of students was removed if it was felt that leaving this information in a quote could lead to participant identification.

A consent form was signed by each participant (see Annex A). In addition, a participant information sheet (see Annex B) was read, discussed, and the participant knowledge was checked to ensure that the participant understood the process. Participants were required to keep the participant information sheet and a copy of the consent form for later use if needed.

4.6.1 Ethics and Participant complaints procedure

At the time of this evaluation being published to the client (Kidpower- Fullpower- Teenpower-Trust), no participants had requested any changes to the information used to evaluate the 'Healthy Relationships' programme.

Participants were informed in both the information sheet and verbally that for any reason, and at any time, they were able to withdrawal their information from the evaluation process. In addition, participants were informed that they could request and make changes to any information during the entire evaluation process up to and including the time of completing this report.

A participant's initial contact for any complaints that related to this evaluation was Kidpower Fullpower Teenpower Trust and their representative Cornelia Baumgartner.

4.7 Reasons for qualitative evaluation only

There were many issues that arose in the collection of survey data in the initial evaluation proposal. As such evaluators chose a qualitative approach to achieve the evaluation goals. Reasons for only using a qualitative evaluation methodology included:

1.) Parent and carer fatigue led to a detrimental reduction in the uptake and quality of information provided by survey and other typical quantitative evaluation methods. Evaluation participants informed evaluators that this lack of uptake of survey methods was typical of the target population.

"We have a lack of parent-kid-school interaction all the time because of information overload, if I want parents there I will ring them personally and then I have more uptake, but not much more. It's less confounding if you call, it is even less confounding if you visit. What you have to do is go to their home to understand their world and they will give back." - Teacher

In the context of evaluating programmes where parents and caregivers of children with intellectual disability are required to give direct feedback substantial resources would be required to achieve acceptable recruitment levels. Specifically, where data was required to detail the nature of programme activities and its benefit to young people in their care, both evaluation staff and the client found quantitative send home surveys and subsequent follow up phone calls were unlikely to produce valid data for the process of evaluation. As such, quantitative methods were not used in this evaluation analysis.

Accordingly, Clarity Research recommends that during phase two of the 'Healthy Relationships' programme roll out, considerable resources be directed towards ensuring that parents and caregivers are involved and the survey method is planned and introduced at beginning. In addition, it would be beneficial for any future evaluation if hybrid methods were used[4] in order to increase the rigour of future data sets and any subsequent analysis. As such, survey information and open ended or semi-structured interviews conducted face-to-face with the assistance of programme evaluators should increase response rates and subsequent data validity in any future evaluation.

2.) Teacher fatigue and current reporting and teaching requirements makes the job of evaluating an additional external programme difficult

Teachers in this programme were observed to have very high workloads and were quoted as saying that there were just not enough hours in the day to participate in additional activities. However, teachers stayed after hours and used lunch breaks to participate in the present evaluation process.

Observations of teachers classrooms revealed reporting requirements on teachers were onerous with just the reporting requirement manuals filling a teacher's desk; as demonstrated in the photo's below (see Visual 1)

4 a mixed method research design involving both qualitative and quantitative methodologies.

4.7.1 Visual 1: Teachers reporting requirements

As such, evaluation staff found it beneficial to discuss the programme one-on-one with teaching staff in an interview setting to ensure in-depth data and in-depth analysis of the value of the programme.

A quantitative analysis of any subsequent programme outcomes will also need a similar in-depth involvement of evaluation staff to ensure rigorous data is collected in a sound and timely fashion.

4.8 Issues with timing: The timing of this evaluation

At the time of conducting this evaluation, the programme had not completed a full cycle.

"Transfer of skills with our kids takes about eighteen months to two years" - Residential staff

"It takes at least two years with our young people" - Teacher

According to participants in this evaluation the programme should observe effective change in the behaviours of young people within eighteen months to two years. Participants, in particular teachers, based this estimate on their practice experience with other programmes.

For example, Residential care workers who participated in interviews for this evaluation stated the implementation of the programme in residence was only two weeks prior to the evaluation process.

"No. At this stage there has not been enough time to judge if the programme has worked in their life, through observing their peers" - Residential Care Worker

4.9 Evaluation Issues: programme length

During the course of this evaluation it became apparent that the 'Healthy Relationships' programme had not been running long enough for the full impact of the programme to become evident. Teachers specifically noted that they would expect to observe an increase in the number of students demonstrating learning of 'Healthy Relationships' objectives and the transfer of skills associated with the programme increasing over time and with repetition.

"I have seen a lot of 'Stop! I don't like it' in half the students, however with repetition and an increase in the length of the programme I would expect to see more students doing this. It's all about the long term with our kids, I predict it could be a full year programme for receptive language groups[5]" - Teacher

As such, future evaluation should be undertaken after sufficient time in order to conclude if a programme has attained its goals.

5 General Findings

The purpose of this section is to outline the general findings of the 'Healthy Relationships' programme.

5.1 Saturated in praise: 'Healthy Relationships' works to make kids safe

In this evaluation the data reached saturation swiftly after the interviews with teachers began. During the evaluation process, evaluators noted a consistently high level of praise for the 'Healthy Relationships' programme from residential care workers, teaching staff, teacher aides, and parents and caregivers right from the outset.

Specifically, participants in this evaluation found simplifying 'Healthy Relationships' and subsequent social interactions down to four basic questions empowering for both expressive and non-expressive young people with intellectual disability and scholastic impairment.

5.2 What's in a name? That which we call a rose…

Across all of the interviews with teaching staff, residential staff, parents, and teacher aides, there has been evidence of some brand confusion.

"I am not too sure if it is called Kidpower, Teenpower, Fullpower, or 'Healthy Relationships'" - Teacher

Over the process of the evaluation, there were countless examples of evaluation participants calling this programme a variety of different names. The most frequently used names were 'Kidpower' and 'Healthy Relationships'. However both were not used in unison and participants used either 'Kidpower' or 'Healthy Relationships'.

"I am not too sure what it's called, I know the programme as 'Healthy Relationships', that's what I call it" - Teacher Aide

5 Teachers who participated in this evaluation described 'receptive language groups' as groups of young people within a class who could demonstrate that they understood language and were receptive to language.

Clarity of brand is important for disambiguation of the programme to parents, teachers, and residential staff:

"I can't remember what it was called now, I just know it was about kids learning to be safe, that's one of the reasons I came to watch" - Parent

Course materials were not at the core of the issue here, as parents could distinguish the take-home letters and survey from others, as well as booklet materials.

"I know the grey 'Healthy Relationships' book" - Teacher

"I remember a flower on the logo" - Caregiver

It would benefit Kidpower Teenpower Fullpower Trust to clarify branding elements and have consistency in programmes according to participants. This is particularly the case for this group of carers:

"Keep your message simple, clear, and appealing, as parents we have 'caregiver fatigue' by the time our kids are ready for independent living" - Parent

All participants were very clear that despite the brand confusion around programme naming, they understood the objective of the programme. This aside, it would be beneficial for Kidpower, Teenpower, Fullpower, Trust to clarify the 'Healthy Relationships' programme's branding elements by brand and by intention to better reflect the demands and understandings of the target audience.

5.3 'Healthy Relationships': The four questions are incredibly useful

All evaluation participants reported that the four questions of the programme were **the most important element in the programmes success**.

According to participants, the four questions a young person should be asking themselves in a social interaction were:

1. Is it safe?
2. Is it okay with both people (or necessary for health and safety)?
3. Is it allowed?
4. Is it not a secret?

Many evaluation participants explained that without simplifying the basic rules of a social interaction, the young people they interacted with on a day-to-day basis would simply not understand when a situation was unhealthy or unsafe. This has led to teachers observing 'Healthy Relationships' as playing an effective day-to-day role in schools.

"the healthy relationship booklet and subsequent role plays and the teaching of the four points are very useful and working in place" - Teacher

"Here was this young woman who had been through this [sexual violence] *but nothing has been as effective, as simple, or as relevant as the four questions of the 'Fullpower'* [Healthy Relationships] *programme. Even though it has been a short period of time."* - Teacher

5.4 Empowerment: What would an effective outcome look like?

Residential care workers, teaching staff, teacher aides, and parents and caregivers stated that once in place the 'Healthy Relationships' programme would demonstrate effective change when the young people in their care developed an awareness of personal boundaries, appropriate relationships and how to seek help from a safe authority figure.

Effective change was also expressed by residential care workers, teaching staff, teachers aides, and parents and caregivers as a mechanism of safety in terms of young people establishing a clear understanding of when things are an emergency and how to be clear about expressing to a safe adult that a dangerous situation is occurring or has occurred in the context of what is socially appropriate and physically safe.

"The main thing that the kids in the department have had is time learning skills that keep them safe on a social basis. They have not learned a lot of things that people need to know to stay safe by comparison to their non-disabled peers… They are concrete practical examples of how to keep yourself safe in any situation. That's the way we have the best chance of helping to keep these kids safe. Just an example... We practice where kids go and get help in an emergency and they expressed what they needed to say to a safe adult. Then a couple weeks later one of the kids had a seizure and the student who came and told me used the keywords from the programme "it's an emergency" - Teacher

6 Role-Specific Findings

This section provides an overview of themes and views from each of the groups interviewed in this evaluation. It was felt by the evaluators that each group had unique insights to offer that built a greater overall understanding of 'Healthy Relationships' and how it is perceived.

6.1 Information from Residential Care Workers

Residential care workers and their management had a role in tutoring young females with developmental and scholastic delay. They were responsible for pastoral care, life skills, and social skills. Residential Care Workers played an intensive care role regarding the behaviour of students in residence.

Residential care workers were quick to point out the difficulty of the situation faced in teaching their classes. The criterion for entry into the residential school is that their academic development is at least three years behind their current age and this presented some unique challenges for the implementation of 'Healthy Relationships' as a new programme introduced to the curriculum.

6.1.1 Residential care workers did not observe significant changes

Residential care workers who participated in this evaluation reported that, at the time of this evaluation, the situation was not conducive to observing changes to residential student's behaviour. Residential care workers gave the following explanations for this:

- The current implementation time frame of only 'two weeks' had not allowed the residential care workers to observe any significant changes to student behaviour.
- The programme, it's actions, and some of the language used by students is "compatible" with existing programmes and as such the 'Healthy Relationships' programme does not stand out against the background of multiple programmes already initiated.

In the first instance, residential care workers who participated in interviews for this evaluation had started the implementation of the programme in residence only two weeks prior to the evaluation process. In their own words they perceived that not enough time had passed in order to see changes in the behaviour of students.

"No. At this stage there has not been enough time to judge if the programme has worked in their life, through observing their peers"

In the second instance, the residential care workers noticed that the programme *"mirrors what has already been done"* and although the programme used different language than other programmes, at the time the participants had not heard the language from the 'Healthy Relationships' programme repeated in the residential situation.

"the other factor is that it is compatible with other programmes and it is hard to tell if this programme has specifically worked. It mirrors what is already done here at the residence"

In addition, residential care workers reported that the language of the 'Healthy Relationships' programme was not established in the vocabulary of the young people at the time of this evaluation, as such they believed that the change in language was not observable due to this short time period.

Residential care workers highlighted that this change in language would be the key indicator in determining if the programme had an uptake amongst the students.

"for example I am still hearing the 'stop, I don't like it' from other programmes rather than the 'no, no, no' from 'Healthy Relationships'"

These comments were cause for confusion for the evaluators as:

a) the residential teachers reported the programme had been implemented for over a period of two weeks in in the residential cottages and,

b) *'stop, I don't like it'* is the phrase others have taught within the 'Healthy Relationships' programme.

These comments highlight that the programme had not been implemented for a significant period of time in residence and as such, the residential care workers had not developed their knowledge of the program sufficiently. Thus, residential care workers may have some misconceptions of the programme and may require more training in order to consistently implement and observe the language of the 'Healthy Relationships' programme.

6.1.2 Residential care workers highlight the confounding factors in assessing the knowledge uptake of the 'Healthy Relationships' programme as it relates to the observable changes in student behaviour

Residential care workers who participated in the interview process stated that the students attending the facility were three years behind their peers scholastically. However, the classes are still grouped by age. The residential care workers highlighted that those with purely behavioural issues rather than intellectual disability tended to demonstrate learning at a faster pace than their intellectually disabled peers.

Thus, the basis for assessment of the 'Healthy Relationships' programme is confounded as each classroom has a greatly varying level of intellectual disability, behavioural issues, and scholastic ability. This will have an effect on the speed of uptake of the learned knowledge of any young person who was in the programme.

"to be a student here without an intellectual disability you must be three years behind your peers, we are a needs-based programme working in a classroom-age-based environment, so in our classroom we have all different levels of learning ability"

This is a point that was to recur through-out the interviews with all groups from all schools in this evaluation and will need to be controlled for in future evaluations of 'Healthy Relationships'.

6.1.3 Strengths: Points of difference

Residential care workers who were participants in the evaluation stated that the 'Healthy Relationships' programme has established three points of difference in relation to other programmes:

1.) In simplifying knowledge down to four simple points:

"There is value in the four steps and we would use it again"

2.) In role-playing real life scenarios:

"the girls grabbed and applied the concepts. The concepts have enough depth and relevance so they can be applied to the outside world, we will have to wait and see though."

3.) In using a digital media in terms of CD's and DVD's which appealed to the young people in residence.

"the CDs and games have been beneficial; it appeals to our young people"

Furthermore parents agree with Residential Care Workers about the use of digital media:

"[gender] *is a television junkie! That's why the DVD is good"*

Based on their practice experience, academic knowledge, and feedback from others, residential care workers expected that this programme would have more success than others based on these three strengths.

6.1.4 Points of difference: Training aids

Residential Care Workers stated that they preferred to use the DVD learning module despite a few cultural short comings:

"the language was awful, it was not customised to New Zealand. It was insulting and very politically correct names, it appeared..... CHEESY yeah! thats it; cheesy"

As such, residential care workers were quick to state that the content of the programme would be more effective if the language of the programme reflected colloquial Aotearoa New Zealand language and was less 'insulting'.

When this point was probed, insulting meant condescending. When asked what they meant by condescending, it appeared that the language of the programme appeared:

"too politically correct"

6.1.5 Teething problems: Collaboration and facilitation with residential care workers

Residential care workers felt that they were not sufficiently informed about the nature of the programme and their role in it. This is evidential by their not knowing how long the programme had been implemented and that the use of the phrase *'Stop! I don't like it'* is part of the 'Healthy Relationships' programme. However, they had strong comments on the general administration of the 'Healthy Relationships' programme:

"Nothing has been very clear at all. Showing us the programme does not tell us what the expectations were. In the end we carried the four things: Is it safe, Is it allowed, Is it okay with both people, Is it a secret?"

"We know role plays; we need a better 'materials briefing'."

This extended to the method of teaching used to train residential care workers and knowledge of programme materials. Residential care workers highlighted that they required more training in the programme and that any training needed to be in line with the training that the teaching staff received.

"We were having training on role playing from Cornelia but we do this already. What we needed was training on how to sequence the guide with the homework book, and the teaching manual in order to deliver the programme effectively and to be in sync with the teaching staff."

In addition, residential care workers required a change to the existing homework materials in order that the homework material, the guide, and the teaching manual were all in sequence. This reflects their experience with other programmes.

"I could not match C4 [section 4 from the 'Healthy Relationships' programme] *with a question in the book, so the book and the CD and the teaching material all need to line up, just like other teaching materials we have here."*

Residential care workers who participated in this evaluation highlighted that if these *"teething problems"* were changed then residential care workers who conducted homework activities with children could deliver the programme with greater effect.

6.1.6 The problem of the teaching and learning context: When touch is okay but not good.

Residential care workers were quick to point out that the programme could be confusing for children with an intellectual disability where the teachings of the programme addressed situations where a young person's health, safety, and well-being were being attended to by an adult in a health and safety situation.

"I was not comfortable with teaching the girls that a doctor can not fix a broken arm because it breaks the four questions of 'Healthy Relationships'"

The example above referred to a situation where a residential care worker or legal guardian of a

child has to take a young person to a health professional to gain medical care and attention. Here the questions of 'Healthy Relationships' were not clear-cut. Specifically:

"Is it okay with both people"

Amongst the residential care workers who participated in this evaluation, a consistent thread was a concern about the confusion created around health and safety when teaching 'Healthy Relationships' to young people with an intellectual disability. Residential care workers were impressed with how the 'Healthy Relationships' programme simplified the basics of a 'Healthy Relationship' around the questions of touch. However, when the question of touch met health and safety, this became more difficult to teach because the simple nature of the programme steps away from real life in the context of a typical young person with an intellectual disability.

Here the residential care workers offer a solution based on existing practice:

"Kidpower steps away from what is real, a young person typically goes to the doctor with mum or dad or a guardian, kids don't do it themselves and they rely on adults to tell them when it is safe"

And a scenario to help with future teaching of the programme:

"I personally spent a lot of time going into depth with this concept. For example when [name] *talked about the dentist I said that a dentist deals with teeth and not your private areas"*

Thus, the residential care workers experience with the 'Healthy Relationships' programme demonstrated that young people are vulnerable and must learn more for their own safety than the four questions of safe touch to be safe; they must also learn when a situation is not safe despite the judgements of others.

Residential care workers' practice experience with the 'Healthy Relationships' programme determined that young people rely on adults for their health, safety, and well-being. Residential care workers have outlined that increasing a young persons understanding of a healthy professional relationship and knowing how to make judgements about what kind of situation they can not trust, and indeed the actions of those adults that make them not trustworthy would increase a young persons chances of avoiding sexual predation and violence.

This said, interviewees from the residential care worker setting stated that the health and safety component of the programme could be difficult to teach in future in both a language and teaching sense.

"the health and safety part was one step too much for our kids, you need to keep it simple"

"'health and safety' is an adult language, health and safety together is a difficult concept"

Many similar statements referred to the need in the four questions to allow 'touch' they are not comfortable with if it is in the context of a 'health and safety' issue. Participants from the residential care worker setting thought this was too difficult to distinguish for some severely disabled people with special needs.

Whilst this may not always be possible for some young people, Kidpower Fullpower Teenpower Trust should consider expanding and simplifying the health and safety element of the programme

6.1.7 Young people and adults: Developing an understanding of where to get help in an unsafe situation

Residential care workers' concern about situational resources extended not only to the problem of the professional relationships but also healthy adult relationships generally.

Residential care workers who participated in this evaluation highlighted that it appeared to them as though there were both sinister and professional elements to some adult relationships in the young person's life and that this could be very confusing for a young person with an intellectual disability or scholastic impairment.

In all instances, the residential care workers were concerned with a young person's ability to know where to get help and what to do if an 'unsafe situation' arose. Furthermore, it appeared that it was not just about where to get help but who to ask for help.

However, the limited time period that the residential care workers had with the 'Healthy Relationships' programme meant that they may have not experienced these modules yet. In some cases residential care workers had real concerns about adults being co-conspirators in 'bad touch', unsafe circumstances, and unhealthy relationships.

"We have done part 'A1' and 'A2' but not part 'B1' and 'B2'. In part 'B1' and in 'B2' we are moving away from reality by not highlighting that in typical situations that there is natural or situational resources to help with this situation. For example adults accompany kids to the doctors and they can make a decision about 'bad touch'. In many cases we see here at [name of school] *mum and boyfriend can be co-conspirators in 'bad touch' but mum and the doctor in a health and safety situation are 'less likely'"*

In either case, data provided by residential care workers and other participants highlighted the need for this program to specify where to get help and that finding an adult may be too general as some adults are simply not trustworthy.

As such the 'Healthy Relationship' programme helped with the basic questions of interpersonal relationships. However, the practice experience of the residential care workers demonstrated that a young person in their care had no tools to help them understand unhealthy relationships and interactions within the professional relationship context without the 'Healthy Relationships' programme.

In contrast the practice experience of the residential care workers who participated in the evaluation of 'Healthy Relationships' reported that the Healthy Relationships programme provided tools to help a young person deal with harm where two or more adults could place the young person in harm in a parent or caregiver relationship. Residential care workers conveyed that achieving this comes down to 'Healthy Relationships' informing the understanding of the young person so that young person could distinguish an unhealthy relationship or interaction.

"Special needs people have processing issues and behavioural issues, all of our young people are at least three years behind their peers academically, for a situation to be safe for them they have to be able to perceive what is safe in every relationship style, Kidpower does this well"

Effectively, this meant that without the 'Healthy Relationships' program young people would not know what to say in an unsafe situation, however as soon as they have said it they need to understand that they must report to an appropriate person what has happened.

6.1.8 Abilities-based training: How residential care workers individualised and taught the 'Healthy Relationships' programme

According to the residential care workers who participated in this evaluation, teaching materials were only effective when tailored to the individuals' learning ability. As the homework aspect of the programme was taught by residential care workers, it was important that they tailor the materials to the specific learning ability of the young people whose homework they supervised. They described this customisation process as abilities-based programing. In essence, residential care workers had found through practice experience that tailoring programmes to the individual had become an important part of the learning process for young people in residence.

"Abilities based programing is very individual, we have individual learning plans, it's about conceptual stuff and it's important we tailor their learning"

Residential care workers stated that this was where 'Healthy Relationships' was most beneficial from a planning and learning perspective, despite it's shortcomings.

"The good thing about Kidpower in general is that it can be customised to the learning plans of our girls. It's based on the kiss (keep it simple stupid) principal, it matches the educational philosophy of our organisation and both the girls and I like the four questions that can be ticked off and remembered"

In terms of abilities-based learning, and despite reservations linked to professional relationships in the 'health and safety' context, residential staff who participated in the evaluation believed the four questions as concepts had three real points of value that will ensure it's continued use:

-Real value in educating young people about the nature of healthy relationships:

"the four concepts have real value in determining a healthy relationship and even our most simple girls picked up these" [6]

-Real value as a teaching aide and learning framework (despite the brand confusion):

"The core tenets of Fullpower are working, even when the DVD didn't work[7] the kids would repeat the four core tenets and carry on."

-Real value in working with an organisation and its staff to help young people understand healthy concepts while complementing existing programmes.

"the four concepts have not changed what we do as staff but it has complemented what we do within our curriculum, it's a very shiny tool in our toolbox and works alongside other programmes to give young people an idea of healthy social skills and relationships"

6.1.9 Residential Care Workers: Summary

Despite some initial teething problems, the residential care workers described that comparing

6 Although this appears to be in direct contradiction of previous criticisms of the program by residential staff, overall residential staff were happy with existing outcomes and their interactions with Kidpower- Teenpower- Fullpower Trust and the 'Healthy Relationships' programme. From interview data it appeared that they anticipated further learning and observable changes as the programme was completed in residence.

7 The DVD not working was the result of antiquated technology at the residential school and not the fault of the resource itself.

'Healthy Relationships' against other programmes in their practice experience, 'Healthy Relationships' as a programme added real value to the young people and it enhanced their ability to maintain healthy relationships through a teaching and learning process.

The programme had simple principles commensurate with the theoretical basis of the residential care workers approach to teaching, up-skilling, and supervising children in their care.

"Even the most limited girls grasped the four items. We would use the four steps again"

Residential care workers observe that the programme has shortcomings in the health and safety area as this element of the programme appears to be unnecessarily complex for young people with an intellectual disability or scholastic disability to comprehend. Thus, if the health and safety element was modified to be far simpler, or broken down into more digestible parts residential care workers suggest that the programme may have more success with young people with a severe intellectual disability in a residential setting.

It would be beneficial for Kidpower Teenpower Fullpower Trust to have some sort of follow-up process with the residential care workers to ensure they know what to observe in terms of the language of the programme. The residential care workers were somewhat unsure of the language of the programme and this may be due to the limited time-span they have spent interacting with the content of the programme or it may be down to the confusion that is created when additional similar programmes are run at the same time as the 'Healthy Relationships' programme.

Residential care workers will need to spend more time implementing the programme and observing the young people in their care before they are able to observe any overt changes in the behaviours in the young people they supervise. However, all residential care workers who participated in this project believe that the simple approach of the programme, the visual examples, and the core tenets of the programme will be highly beneficial to young people when these core tenets are applied in an abilities-based learning model.

6.2 Teachers and Teaching Management

Teacher and Teaching Management who took part in this evaluation had, on average, more than 10 years experience in their field and were specialists in teaching children with intellectual disabilities, behavioural issues, and scholastic impairment. All Teachers who participated in this evaluation were quick to describe their role as one that attempts to impart their students with knowledge despite the intellectual disabilities and behavioural issues that arose with this group. The Teacher and Teaching Management interviews (hereafter referred to as the teacher interviews) were conducted with two teachers from a residential school who were currently using the 'Healthy Relationships' programme; two teachers from a school that had a series of classrooms devoted to special education; and one manager of a special education unit.

6.2.1 Teachers have used 'Healthy Relationships' to help young people analyse and respond to sexual harassment situations.

Teachers have used the 'Healthy Relationships' programme in an attempt to improve the behaviours of their students in 'unsafe' situations. Teachers use 'Healthy Relationships' to change the language and behaviours of their students. Teachers described situations where students changed or analysed their behaviour as a result of using the 'Healthy Relationships' programmes method.

"For example a student kissed another student. '[gender] *screamed "*[name] *kissed me, but I didn't*

like it miss!" Sooooo, we went through the 'Healthy Relationships' process of asking if they had told the other student 'Stop!, I don't like it'. The student recognised that it was not okay and that they needed to sort it out with the other student. That is the miracle. Here no other programme does this so simply."

The Teacher who was quoted above described, this student's response prior to the 'Healthy Relationships' programme as 'usually resulting in violence'.

She usually has no way to express herself so she would lash out without ever talking about feelings, instead we sat down and asked what should we do with them after this incident rather than lashing out with violence"

'Healthy Relationships' has changed teaching practice through adding a simple and effective tool to enable teachers to walk students through how to express themselves when they were in a relationship or interaction they do not wish to be in.

6.2.2 Repetition Repetition Repetition: Teachers explain repetition and structure as core methods of the programme

Teachers who participated in the evaluation describe two key elements of the programmes being beneficial to the overall learning and retention of knowledge by students with intellectual disabilities, scholastic impairment, or developmental delay.

The first element was clear structure and thorough strategic learning:

"Our kids are very concrete in all situations. Kids have a hard time learning so it comes down to strategies for learning. The overall presentation of any education needs to be unique and memorable, ready to use material, ready to go. The teen power stuff is really like that. Useful as materials and for professional development. The very prescriptive way of doing this meant my students and I learned a lot from Cornelia and Kidpower."

The second element was repetition; the programme was repeated constantly in all environments:

"The kids need repetition, as I said kids are concrete in all types of situations and so once you learn what to repeat then you practice. That is the way that has the best chance of working"

Along with these two elements, role-play of real world scenarios was an important element for learning in this population.

"A rock through the window, pot boiling over, student having a seizure, the children need to learn initially that 'it is an emergency'."

Learning has clearly occurred with at least one student directly as a result of this method of learning the 'Healthy Relationships' programme.

"and in one case we had a child with a seizure, where usually our young people would have not responded appropriately, a girl came and told [me]"

As a result of the combination of repetition and clear structure the four simple rules were able to be absorbed by responding students and behavioural change did occur. As you will see, customisation of the programme to classrooms using these basic elements is reported as essential

to the success of the programme.

6.2.3 How Teachers made simple concepts even more simple

Prior to learning the four questions of the 'Healthy Relationships' programme, teachers had to develop in their students an additional set of cognitive and social skills to complement the programme. This was achieved through the creation of some very basic additional learning steps designed with the goal of enhancing the uptake of the ideas of being safe and avoiding danger. As discussed later, the knowledge of being safe and avoiding risk was clearly beyond the cognitive skill set of many students initially. In addition the 'Healthy Relationships' teaching material assumes that all children are capable of learning what being safe and avoiding danger means.

"With the Kidpower programme we had to build up to being aware of danger with our kids, they had to know when it is urgent, you have to know the correct person to get help from, you have to be able to communicate this. It is easy to take for granted how stuff that is so simple to us is just so very hard at every stage or point for these kids."

This led to teachers refining the programme in conjunction with Kidpower Teenpower Fullpower Trust staff in order to develop some new methods to help the students understand what is typically taken for granted by other children and parents as part of the process of learning in the social world.

This included:

-simplifying how to negotiate social barriers:

"We had to explain how to get attention when it is a real emergency, in our role plays we put up barriers and role played with the kids how to get around them to get your message across"

-Developing an awareness of what was urgent:

"A session was using a bunch of pictures and allowing the children to determine was it urgent, was it not urgent. Urgent was eventually described when someone's health or safety is at risk."

In combination with the four questions of the 'Healthy Relationships' programme and the repetitive and structured approach of the programme, teachers simplifying the context of the programme led to improved results displayed in the decrease in inter-peer and classroom violence.

"I have seen a lot of kids who are being violent. The kid power programme and language has seeped into the kids over time to the point where if a kid tries to steal another's lunch then they say 'Stop! I don't like it'

As a result, Teachers were able to sum up the change in language and the subsequent prevention of violence in one simple sentence:

Nothing is more teen power than 'Stop!, I don't like it'."

6.2.4 Teachers were able to adapt the programme to classrooms to achieve results

Teachers adapted teaching and learning methods of 'Healthy Relationships' using the core methods of the 'Healthy Relationships' approach. As a result of this adaptation process, the classroom responded to 'Healthy Relationships' as a highly effective and simple approach which

changed the short-term violence outcomes as seen in peer-to-peer interactions. This was achieved by the teacher adapting the programme's content into participant-relevant formats so that participants learn new forms of emotional response, appropriate behaviours, and new forms of safe social expression around peers.

"I have ten students out of ten; they all have new social skills as a result. The first thing I did was make a healthy relationship colouring page. They have all shown change: some in leaps and bounds or some just coming out of their shell. Just the fact that we are doing this is amazing."

As such, the core tenets and not the exact method of the programme were followed, demonstrating that it is the core of the 'Healthy Relationships' programme which was most beneficial.

"I didn't follow the book I followed what was in the book"

Teachers described the teaching and learning components of the 'Healthy Relationships' programme as highly effective by comparison to other programmes as the programme concept demonstrated greater transfer of knowledge and skills amongst their students than any other programme. As a result 'Healthy Relationships' had clearer outcomes than any other programme that these teachers had experienced.

"I have not seen anything that even approaches this in terms of its learn-ability and teach-ability"

6.2.5 Teachers and Teaching Management say 'Healthy Relationships' has had real world implications

'Healthy Relationships' has a substantial role play component. In more than one case, the role plays of real situations had real world implications for students questioning what to do about violence in their own home.

"I had one student say to me 'when I get home I will tell my [gender] *'STOP! I don't like it', and this was a very limited* [gender]*"*

As such, students learned skills that they could transfer into real world situations and were intent upon using this approach to prevent violence and harassment.

Teachers who participated in this evaluation stated that in comparison to other classrooms that did not use the programme, their own classrooms were ahead in terms of social skills and displayed a decrease in violence and an increase in teamwork

"We seem to be better equipped than other classrooms and getting on better as a team with a noticeable calm to the classroom. I think this means my students are not as agro as they used to be"

In particular, some young people changed their violent responsive behaviours when faced with a situation where they did not feel safe or confident

"We have another boy who instead of sticking his neck out and saying 'fuck off!' he now says 'Stop!, I don't like it' and comes and finds a teacher. Usually with his condition he just couldn't do that."

These changes are significant behavioural modifications, as young people learned to change their reactions as a result of 'Healthy Relationships'

We have one young girl who can now walk away and say 'Stop!, I don't like it' instead of punching people

Teachers and Teaching Management noticed a pronounced, significant change in some students with all demonstrating at least some change. In addition to a decrease in violence responses to external stimulus, 'Healthy Relationships' has allowed many students to question their own compliance to the requests of others:

“One hundred percent improved in some way, all our kids, in fact the whole lot, have improved because they now all say no. Before people would have been over-compliant and they would have said 'yes' to everything in the world”

This reduction in over-compliance extended to young people who had historically been particularly vulnerable to sexual violence due to their over-compliance to the requests of others. These young people were observed by teachers saying ‘Stop! I don't like it ’ and more importantly 'no'.

“For example we have a very compliant very pretty girl and she was always saying yes and this form of compliance got her into trouble in the past. She says no now and that just means so much in terms of her own safety, it's unbelievable!”

Thus, young people who had participated in the 'Healthy Relationships' programme have learned to express themselves in social settings. This has lead to a noticeable reduction in aggression and over-compliant responses in the school yard. As such, young people were learning as a result of 'Healthy Relationships' to express themselves in real world situations to maintain their own safety by negotiating the social world using the four key questions of 'Healthy Relationships' and using the learned response taught during the 'Healthy Relationships' programme.

6.2.6 What is new in teaching practice as a result of 'Healthy Relationships'

'Healthy Relationships' has brought a range of new teaching methods to one of the trial schools, and has fitted in well with the teaching methods of the other trial school.
Schools whose Teachers participated in the evaluation all found the programme useful in creating a new way of learning for the students they taught, and this learning was specific to identifying the social nature of healthy relationships for young people who appeared unfamiliar with the social world.

“It's a new way of teaching. The ‘Healthy Relationships’ booklet, subsequent role plays, and the teaching of the four points are very useful and working in place with our children”

The teaching method had brought a shift in practice to the teaching staff who participated in this evaluation. Role-plays were found to create beneficial outcomes and the 'Healthy Relationships' programme was therefore beneficial to the well-being of children by ensuring that teachers utilised the role-play when explaining the framework of the four questions.

“It reminds me that we must have lots of role playing...It's like giving you a polish on a system which makes the process work.”

As such, teachers reconfigured their practice to be more kinaesthetic as the role-plays provided

significant improvements to the social understandings of the young people they were teaching.

6.2.7 Outcomes: 'Healthy Relationships' enabled the reporting of sexual violence to authority figures

Teachers who participated in this evaluation described that in particular the role-modelling and visual teaching aids in the book provided a powerful set of common examples for young people to recognise and that this aided in the reporting of sexual violence to teachers.

"When you're role-modelling to the students and they think 'you do know something', this helps with the girls coming to me and reporting sexual violence, there are two counsellors and as soon as it comes up we send the girls straight to them."

When given real world examples that students could relate to, teachers soon found themselves fielding questions and discussions from young people who had experienced violence and in particular instances of touching that could have led, or had led, to sexual violence. As a result, the content of the 'Healthy Relationships' programme had enabled some young people to come forward, report sexual violence or harassment, and seek further assistance. This is of tremendous importance and has significant implications for the success of this programme as defined in the evaluation objectives.

6.2.8 Weaknesses: Confusion around the four questions and health and safety

Similar to the residential social workers interviewed, teachers who participated in this evaluation stated that the health and safety element of the four questions of safe touch were confusing for their students.

"There is a bit of confusion around what is allowed regarding the health and safety question"

6.2.9 Fixing Weakness: Clearing up confusion around the four questions and health and safety

To the teachers credit, many teachers found that by asking students to recognise 'feelings of unease' and working with students on that feeling; they could then approach the health and safety exclusion with confidence and remove the confusion by discussing with the student when a feeling of unease was out of context.

"with repetition they were able to distinguish the physiotherapy context from a sexual harassment context by using the four points and you teaching the kids to look out for that feeling of unease in the pit of your stomach"

Teachers stated that the health and safety issue was important because amongst their students there were significant health issues that needed to be addressed, but could not be addressed if the four touch questions were applied literally in all contexts.

"maybe a doctor, maybe a health nurse. Our guys have real hygiene issues and they need to be seen to. You can't do that if all unwanted touch is not allowed"

As such, Teachers agreed that if the health and safety part of the programme was changed to simplify the context of touch then young people with intellectual disabilities generally would be able to decide when a healthy professional relationship or interaction turned unhealthy.

6.2.10 Dislikes: Training from the teachers perspectives

Some teachers who participated in this evaluation described the programme implementation as lacking the background training that they expect. These teachers would prefer to have additional theoretical background training on the 'Healthy Relationships' programme. This would be in addition to simply going through the booklets

"The healthy relationship programme is a touch piecemeal as it comes in. Cornelia is quite passionate and she responds when we have requests, it's like any course. I believe we should have a day of training about the programme, this day would enable us to change the programme"

Teachers stated that this would need to be addressed in order for teaching to be effective for any other teachers as adequate training was reported as being part of teaching culture for new programmes.

6.2.11 Dislikes: Naming of characters

Some teachers who participated in the evaluation felt that the names of the characters in the booklets and teaching materials were inappropriate for the Aotearoa New Zealand context

"There were a few things, like names are a bit out there"

"Change the names of the characters to something more realistic"

Whilst some teachers who participated in this evaluation stated that the names used and other components of this programme were considered "a bit out there" other teachers stated that this was not an issue:

"Great names. Very multi-cultural." "PC is not a bad thing."

This conflict exists due to the familiarity of language around the names in the programme, not due to the political economy associated with the programme itself. In essence this means that names of people in the booklet needed to reflect an Aotearoa New Zealand context so that students could relate to the booklet from names and places that exist in their social world. This would serve to make the programme more in line with the day-to-day reality of both students and teachers. The practice experience of teachers who participated in this evaluation suggests that where readily identifiable and familiar examples are used, these examples can aid the teaching and learning process.

6.2.12 Dislikes: Difficult or complex language or ideas

Teachers described language as being a significant barrier to learning when beyond the conceptual understandings of the student. In the context of the practice of the teachers who participated in this evaluation, some of the language and concepts used in 'Healthy Relationships' presented students with new and difficult concepts far beyond that they would typically understand.

"with our students the language set does not give the understanding, for example boundary is a big enough word. Too big to be dealt with."

In the above example, 'boundary' is a very important concept to the programme. However, this concept required a further breakdown into easily digestible teaching and learning processes in

order for the student to be able to learn what a 'boundary' is.

Teachers described teaching students with varying intellectual disability backgrounds. This posed a unique classroom teaching challenge when it came to recognising and questioning unsafe situations. This meant that the transfer of knowledge would take longer with some students then it does with others:

"the transfer of skills with some students takes two years, the transfer has been noticeable overall, but it is more noticeable in those of a higher IQ"

During the evaluation, language issues raised appeared to be reflective of the need to change the learning materials to match the comprehension capabilities of students who would participate in the programme. Some teachers were able to do this by breaking 'big' concepts down into their component parts. Others did not and changed the programme to exclude these concepts. Either way, the programme appeared to be more beneficial to young people when it was customised to the classroom or individual learning ability.

Changing the program for all participants involved using the teachers guide provided by Kidpower-Teenpower- Fullpower Trust, which invites customising to adapt material to the classroom method using existing classroom teaching aids.

"These were complex ideas and using familiar teaching aides helped the kids learn a lot quicker. Cornelia helped us with this. Later on I broke the language and concepts down with her help but this took a long time. The next schools will hopefully be able to take advantage of this"

6.2.13 Teachers and Teaching Management summary

Teachers and Teaching management can see benefit in the programmes content and method of teaching. They typically find the programme easy to adapt to the needs of their classrooms. As such, teachers found that the programme works to aid young people to express to others when they are uncomfortable with a relationship or social interaction. Overall, teachers found the programme had real world value in delivering results.

In terms of preventing sexual violence the 'Healthy Relationships' programme gave some students the confidence to communicate to teachers instances of sexual harassment and sexual violence in their own social world. Thus, after these instances are exposed and dealt with, the potential to prevent further sexual crime has occurred as a direct result of the programme. Numerous studies have shown that sexual offenders are likely to have committed multiple sex crimes[8].

Violence prevention also extended to classrooms and the school yard in general. Teachers reported that beneficial classroom behavioural changes had occurred as a direct result of 'Healthy Relationships'. Where violence was once a normative response to unwanted interactions, now a new set of classroom behaviours which included teamwork and expression of dislike had occurred.

Teachers in particular displayed an enthusiasm for the programme through their desire to create strategies to overcome student confusion when dealing with difficult concepts such as 'boundaries' 'safe and unsafe', 'emergency', 'danger', or the 'health and safety' element. This enthusiasm also came through in the suggestions to normalise the training process to be in line with what teachers expected and in line with other commonly used and recommended programmes. This highlighted that teachers were very keen for other schools to have this programme as a resource.

Finally, it would appear that despite the 'short-comings' of the early programme trial versions

8 see for example Furey (1994)

reported, teachers who participated in this evaluation had embraced this programme because of the benefits it brought to the classroom; particularly changes to the reporting and incidence of violence, and the changes it brought to the expressive capability of the young people in their schools and classrooms.

6.3 Teacher Aides

6.3.1 Teacher aides felt ill-informed by role

Teacher Aides who participated in this evaluation described themselves as being ill-informed in regards to the theory, resources and activities of the 'Healthy Relationships' programme. However, this was more a result of the nature of the role of a teacher aide. Teacher Aides described themselves as working 'in the moment' under the clear and direct instruction of the teaching staff with very little need to know why they were asked to do something:

"I am a Teacher Aide. I give Support where needed."

"I get no information, I just get told what to do."

"Um.. Teacher Aides support. The Teachers write the programmes, the Teacher Aides support the programme. We help with social skills, community interaction, just in any way that we can."

"We have some students that are high need, we sit beside these students and make the basic even more basic."

"I am dealing with whatever student, in whatever way. I can to get them understand."

Although it would appear as though Teacher Aides were purely responsive to the needs or requests of the Teaching and Teaching Management staff, the closeness with which they worked with the young people in the 'Healthy Relationships' programme meant that they could observe behavioural changes and learning that Teachers and Teaching Management would not typically observe in the classroom and playground situation.

6.3.2 Teacher Aids saw beneficial change in student behaviour

Teacher aides were swift to discuss, unprompted, the nature of change seen in young people as a result of the 'Healthy Relationships' programme.

"Kidpower has not done anything for me in this role but it has done something for the kids. It has made the kids more aware of their personal safety. We are here to look after the kid's personal safety. Outside of school is what this programme tends to be about, the bus, the mall, etc."

Here, behavioural changes were noticeable over the short period the programme had been in place. It was very clear speaking to all teacher aides that they saw a major turn around in students being aware of their own personal safety. For young people with an intellectual disability, it appeared that personal safety was a hard concept to grasp until the intervention of the 'Healthy Relationships' programme.

"Before Kidpower these kids wouldn't have a bloody clue if a situation was unsafe or not, now... well it's like night and day!"

In this evaluation, teacher aides suggested that their knowledge of the programme extended to

what was happening in the moment and as such, they were unable to tell if it was working in specific detail in the outside world; with two key exceptions:

6.3.3 From school to home: Teacher aides and their own children

During the course of the evaluation it became apparent that at least one of the teacher aides using the 'Healthy Relationships' booklet began to apply the principles of the programme at home.

"I thought Kid-power was very informative, not only for students but for us as well. When I say that, I have a [age] *year old* [gender] *so... I often feed back some of the things we have in teen power and kid power to my* [gender]*."*

6.3.4 What is a friend/Who do you hug with: Big concepts for students with intellectual disabilities

Similar to many other respondents, teacher aides who participated in this evaluation displayed a concern that young people with special needs may not be able to grasp some key concepts in the 'Healthy Relationships' programmes. Specifically, teacher aides described 'friendship' as a complicated concept for young people with special needs to conceptualise and generalise from role playing situations in the real world.

"Some of it was confusing for me. You get that scenario: it's okay to take a lolly from a friend, but not a stranger. Our Juniors are not familiar with where the friend stops and where the stranger starts."

As with other professionals interviewed, teacher aides were concerned that some of the young people are not capable of comprehending basic concepts, such as 'friendship' and therefore the role plays may be beyond their capabilities. However, teacher aides described that this was a minority.

"It would be about twenty five percent or so who are just never gonna get it, but that twenty five percent would have minders all the way through their lives"

One such concept was the ability to distinguish between friendship, love, and abuse. Teacher aides questioned the ability of the young people to grasp complicated ideas.

"That is why it is important; they are at an age where they do want it. They can't distinguish the difference between abuse and love. They know their school friends. I don't know what the situation would be when the kids meet strangers."

Generalising what is learnt at school into the 'real world' is a difficult enough task for anyone and for some young people with an intellectual disability, scholastic impairment, or developmental delay the particular challenges understanding some of the concepts dealt with by the 'Healthy Relationships' programme may simply be to big to grasp. However, the young people who cannot learn the most basic concepts are the ones that will be looked after 24/7.

6.3.5 Transfer of skills: Physical expressions as evidence of effective programme uptake

All Teacher Aides spontaneously described that they had seen the young people they work with using physical responses learnt during the 'Healthy Relationships' programme.

"I have recently seen the kids doing the 'Stop! I don't like it' thing to kids in the other departments.

Including the kids kissing because they now say 'stop I don't like it' if they don't like it"

Teacher aides in classroom situations suggested that children with special needs displayed difficulty with participation in any activity. However, this could not be said for participation in the 'Healthy Relationships' programme:

"I noticed changes in all of them, a one hundred percent of them were more confident, confidence is a big thing. All of them really enjoyed doing the whole role play and everything. Every time we had Teen Power, we always had people so keen to join in. Before Teen Power they would not have stood up or even interacted."

Despite this assertion, teacher aides qualified this report with the fact that the young people's level of functioning determined the observable outcomes. In the classroom situation a quarter of one classroom who participated in the 'Healthy Relationships' programme did not verbalise.

"Five out of twenty of the kids in this class cannot verbalise or even indicate if it works. The only way I know if they don't like something is if they are violent"

Issues around the ability of some young people to display learning of the 'Healthy Relationships' programme could be seen by teacher aides in their practice experiences:

'Whatever you say last sometimes gets picked up. If you say 'do you want a red ball, green ball, or blue ball', they will say 'blue ball' because it was the last thing you said'

Some teacher aides noticed that some children on the autistic spectrum did not indicate that they understand very much at all other than what was repeated to them at the end of a sentence. In addition, some students were incapable of expression altogether, regardless of intervention.

With autism you don't know what they understand. There is stuff going on in there but they can't verbalise it, so they tend to get violent. It's a defence mechanism.

Other teacher aides professed that although they saw participation in the classroom, sometimes this participation did not translate in certain situations in the 'playground'.

"But sometimes they forget so it's a bit sporadic. It comes to the point that the kids don't want to say Stop! I don't like it... Even so, they would still do it if it was a real stranger, maybe just not if it was a friend sometimes. It's complicated!"

As mentioned earlier, some children with special needs are unable to delineate the concepts of friend and stranger, however it has also been suggested that those who could delineate benefited highly from the simple physical actions and short sentences taught as part of the 'Healthy Relationships' programme.

6.3.6 The relevance of 'Healthy Relationships' to students at the lower end of functioning

There were some issues raised about the benefit of the 'Healthy Relationships' programme for young people at the lower end of functioning in the classroom. Specifically, as previously mentioned, teacher aides noted that approximately twenty-five percent of the young people in their classrooms were very *"low functioning"* and would never be in the position of being unaccompanied on a bus or in a mall.

As a result, the role-plays may not have been relevant and the young people may not be capable of learning what had been taught. Around this 'lower end' children displayed an incapacity to demonstrate knowledge of the programme

“The four questions...Yeah, they don't really know those but you have to remember that these kids can't even remember their birthday some of them, I think you'd struggle.”

However, teacher aides stated that this was not really an issue if the supervisor is safe, as children and young adults who experienced this level of dysfunction were always under adult supervision.

“How does this programme work for lower ability kids? It seems more relevant to the senior pupils because they will be far more independent going on buses etcetera”

The question must be raised however about the nature of supervisors of young people with intellectual disability.

“If they know somebody it's okay, the problem is when somebody they know is abusing them.”

This also raises a question about the relevance of what is role played as 'lower functioning' youth are never on a bus, in the mall, or in public social situations without close supervision. For the children at the 'lower end' of functioning, potentially the programme could be directed to specifically focus on carer abuse and inter-peer interaction, rather that role playing abuse on buses and at malls.

6.3.7 Teacher aides summary

Although teacher aides described themselves as being ill-informed in regards to the theory, resources and activities of the 'Healthy Relationships' programme, they were key observers of significant change and improvement in the lives of young people who had an intellectual disability, scholastic impairment, or developmental delay as related to the 'Healthy Relationships' programme. Teacher aides saw an improvement in the behaviour and expressive nature of the young people they supervised.

Teacher Aides observed that some children could not express or display that they had learnt anything from the 'Healthy Relationships' programme. These children clearly had different needs, for example the need to be aware of caregiver violence and harassment as they were in care twenty four hours a day. As such it was important to observe that these children may need a similar programme but one that is targeted for this specific need..

Teacher aides, like teachers and teacher management, observed that young people who had intellectual disability, scholastic impairment, or developmental delay struggled with concepts that others take for granted. They described these concepts and detailed that they needed breaking down into easier components. This is possibly the most important lesson for the success of the programme.

Overall teacher aides could benefit from attending an initial training alongside teachers. This will enable them to be better informed as to the objectives of the programme initially and may enhance the teaching learning experience along with their ability to observe appropriate outcomes in the students.

6.4 Parent Interviews

6.4.1 Parent Background Survey

As explained in the method section, the parents and caregivers participated in a survey prior to the qualitative component of this evaluation taking place.

In the parents/caregivers survey, the first few questions asked about their young person's risk of sexual abuse, in particular, specific situations or places they believed their young person may have been at risk of sexual abuse, what they as parents had said to their children about personal boundaries and being sexually safe, along with any specific concerns they had about their own child's safety. The results showed that half the twelve parent/caregivers who responded identified public places as the main situation where their children were at risk, as well as social situations that their children may be involved in occasionally. Many had talked with their child about not letting anyone touch their 'private parts' or not to touch those of others, but the survey identified that most found it difficult to approach this topic with their child and to 'make it [the information] stick'. Other concerns were that their child's vulnerability would increase as they got older and especially when they moved out of home.

The questionnaire also attempted to gather information about the parent's participation in, or prior knowledge of, any information sources that focus on issues of personal safety for teens with disabilities. It also asked if they had any recommendations for a pilot programme that would help the parents and young people to deal with specific safety issues and prevent sexual abuse. The overwhelming response to these questions was 'no', and it appears there are no networks that specifically address issues of personal safety for teens with intellectual disabilities.

Some recommendations for the pilot programme suggested that parental involvement was necessary, that information be presented visually and as openly as possible, with the use of role plays. Mention was made of a complementary programme available through the Down's Syndrome Society.

Many parents said that they would like to be involved in the programme so that the information can be reinforced at home.

6.4.2 Parents Role

Parents and caregivers described their roles as being the organiser in the day-to-day lives of the children in their care.

"What ever [name] *needs, I will try my best to do it for* [gender]*, without me* [gender] *couldn't do life"*

6.4.3 Exhausted parents and Caregivers: Carer fatigue

Parents and caregivers who participated in the evaluation of the 'Healthy Relationships' programme described issues of carer fatigue preventing them from being fully aware and involved in their child's lives. Parents and caregivers who participated in this evaluation described being in a state beyond the point of information overload, and experiencing mental and physical exhaustion.

"Some parents acknowledge parental fatigue, but carry on regardless"

However, some Parents or Caregivers were involved in the day-to-day lives of their children and

some were unable to be involved. This usually depended on the age of their child.

"The parents of the students at the age of 19 or 20 have fatigue. At this stage most parents need a break. Someone should research this."

"After 17 years you're just over it"

Many Parents and caregivers who participated in the evaluation were aware that 'Healthy Relationships' was being taught but were unclear about what 'Healthy Relationships' was teaching. Parents detailed a belief that the school does an excellent job and that this belief lead these parents to allow the school to take control of the teaching and learning of their child during school hours and led to the belief that 'Healthy Relationships' would be beneficial their child.

"I know next to nothing, they sent home a notice, and they send notices all the time so it's just a bother sometimes, I just let them go-for-it; they know what they are doing"

For this reason it was difficult to discuss with parents and caregivers directly whether or not the programme content of 'Healthy Relationships' was making a difference in the lives of young people who participated in the programme. Some parents were concerned that they were not well informed:

"parents need to be informed, to know what their child is doing, and give consent on that knowledge...we only heard of Kidpower today"

However, almost all parents and caregivers were simply exhausted by the amount of information and interaction they had as parents in their young person's life.

6.4.4 Parents concerns: Understanding parents

Parents and caregivers had very real concerns about their children experiencing sexual violence and unwanted sexual attention. Parents and caregivers shared their greatest fear as unwanted sexual attention manifesting itself in their child's life and that their child had no way of expressing that they did not want the unwanted sexual attention or harassment.

"I was at a conference, a young man came up and touched her breast, she froze and didn't say anything. Here I am telling her no and stop and she still didn't do anything. So it needed a new approach to teach her what to do. Giving physical permission to say no as well is so very important.

In addition to unwanted sexual attention from strangers, parents detailed their fears about potential dangers from carers and known figures in the young person's life:

"Carers; I worry about these. You tend to hear about these, you know, that some carers are not doing this for the right reasons. I hope that this programme is able to provide the tools"

Parents had their preferred solution to the situation. Parents and caregivers often stated that education was at the centre of their beliefs around how their young person would be empowered to cope with real world danger in relation to sexual harassment and violence.

"The New Zealand stats are terrible. But, wrapping her in cotton wool is not the answer, education is, so when she transitions into the world and I have to let go, and hope she relies on that

education, we need to know that they are safe."

In short, parents and caregivers are relying on 'Healthy Relationships' and other similar programmes to sink in and give their children the tools to handle these unsafe situations. As such, it is important for Kidpower Teenpower Fullpower Trust to recognise parents and caregivers perspectives and attempt to connect with all stakeholders to understand how to achieve parent's and young people's goals. This said, during the entire interview process there were no complaints about the program itself only complaints about the nature of the situations happening to their children that were outside their control.

6.4.5 Informed parents: What was working alongside 'Healthy Relationships'?

Parents and caregivers who had worked alongside their children during the 'Healthy Relationships' programme had discovered that customising the method of teaching to the student's method of learning could potentially yield better outcomes. This took many forms most of the examples given to evaluators during the interview process were about the visual representation of characters in the 'Healthy Relationships' booklet, CD, and DVD.

"[young person] *responds to photo's of themselves rather than black and white cartoons. It could be more personalised in some instances for better recognition"*

For parents who experienced the programme and had children who had difficulties with expression, the programme enabled them to notice changes in expressive behaviour linked to the 'Healthy Relationships' programme. This is different to the information given by teacher aides and teachers, however nevertheless significant.

"this year he is interested in being dressed up and dancing and participating with others"

Changes noticed by parents in non-communicative young people were more subtle and seemed to be changes in demeanour only really noticeable by a parent or caregiver with a long history of interaction with their child.

6.4.6 Parents and caregivers summary

Because many parents and caregivers had not participated in the programme, they did not really have an understanding of the nature of the programme's activities and intended outcomes. They were therefore unable to provide evaluation staff with any specific instances of where the programme had changed the behaviours of their young person in the manner intended by the programme. Many parents reported they were already teaching their children about staying safe and there was no obvious difference in their child's behaviour since the start of 'Healthy Relationships'.

"It's hard to judge if Kidpower is better than the others"

Parents and caregivers who participated in this evaluation had varying levels of knowledge about, and interaction with, the programme. Overall, parents were unable to provide instances of change brought about by the programme. This can be put down to:

- Carer fatigue;
- Knowledge deficit in terms of knowing the ins and outs of the 'Healthy Relationships' programme and what to look for;

- Information overload in which carers are constantly bombarded with programmes and daily life choices to the point where it creates confounding and confusion about outcomes attributable to various programmes.

Engaging parents in this evaluation and the programme itself may prove difficult as a result. It would be beneficial to the evaluation process in future to involve the Parents and Caregivers in the programme. However, considering the levels of 'carer fatigue' that many parents reported, it may not be beneficial to include some parents.

Parents and caregivers are the ultimate authority in the lives of a young person with an intellectual disability as they observe changes in that person's behaviour that are not noticeable to people who have been with their child only a comparatively short time. They are also more likely to see evidence of programme objectives generalising to situations outside the controlled school environment.

7 Conclusions

The interviews conducted during this evaluation have led to a number of conclusions. These are discussed below.

7.1 Simple things to change

7.1.1 Clean up the branding

Part of the confusion over the name of the Healthy Relationships programme was generated by Kidpower Teenpower Fullpower Trust being involved in previous programmes with the schools. However, it would benefit Kidpower Teenpower Fullpower Trust to clean up 'branding elements' ie; the name of the programme. This can be achieved by:

1.) Having consistent logo's and matching language.
2.) Removing previous programme information.
3.) Using 'Healthy Relationships' as the programmes brand and removing any additional branding elements from the booklets.
4.) Developing more coordinated training procedures for stakeholders

7.1.2 Keep it Aotearoa New Zealand

Some participants complained that the names of the people in the programmes and the behaviours were not 'typically Aotearoa New Zealand'. As such, it may be beneficial for Kidpower Teenpower Fullpower Trust to research and implement more colloquial names, places, and some situations in order for the programme to increase it's salience to a Aotearoa New Zealand audience.

7.1.3 Simplifying large concepts with 'large language'

Evaluation participants were quick to realise that young people with special needs, scholastic impairment, or developmental delay struggled with the big concepts with 'large language' in the programme. Similar concepts came up repeatedly throughout this evaluation's participant sample:

1.) 'Boundaries'
2.) 'Friendship'
3.) 'Safe and Unsafe'

4.) 'Emergency'

5.) 'Danger'

It appears important that young people with intellectual disability, scholastic impairment, or developmental delay are able to grasp these concepts for the programmes success. As such, Kidpower Teenpower Fullpower Trust should invest some time into discussing with teachers, teachers aids, and teaching management how these concepts were broken down for young people by them in conjunction with Kidpower Teenpower Fullpower Trust staff during the course of the programmes implementation. This revisiting of the simplification process undertaken by teachers and Kidpower Teenpower Fullpower Trust staff will enable the important learning achieved during the implementation of 'Healthy Relationships' this year to be translated into permanent improvements for future of the programme.

7.1.4 Create a specific programme for 'lower-functioning' youth

As explained by teacher aides, teachers, and residential staff, some young people are not going to understand the programme and will always be in care. Here there is a very real concern that carers could be potential abusers. If that is the case, Kidpower Teenpower Fullpower Trust could adjust their programme when targeting 'lower functioning' youth, to take account of carer-specific abuse.

7.2 Additional Training measures

7.2.1 A day session for staff involved in teaching the programme

Teaching staff required additional training. In phase two of the roll-out of the 'Healthy Relationships' programme in other cities; where Kidpower, Teenpower, Fullpower, Trust staff would not be as readily available to be on-site at short notice, a day's training which covered the programme content and enabled staff to modify the programme to their classrooms abilities may prove beneficial.

7.2.2 Invite the Residential Care Workers to the teaching sessions

If the school is a residential school, inviting residential care workers to the first half of the training day could prove beneficial to the coordination and ultimate success of the programme.

7.2.3 Invite the parents

If the school is non-residential, inviting the parents to learn the programme could have beneficial outcomes for the parent's awareness of the aims and expected outcomes of the programme along with their motivation and ability to help with the homework modules of the 'Healthy Relationships' programme. However, judging by the evidence to hand, it would appear that 'Carer fatigue' will be a significant hurdle to overcome.

7.2.4 Formalise teaching of the programme around the basic customised application of the programme.

Typically, when customising the classroom modules, this was done at the average level of the classroom ability or was individualised by teacher aides for the students at the time of learning. Also, an abilities based approach was most beneficial during the homework phase. Thus, when customising the programme:

1. Teachers consider the ability of students in their class and the accessibility of the four basic concepts; then tailor the programme to suit.

2. Residential workers consider the individual abilities of each young person and tailor the programme to suit to that young person's understanding of the concepts.

3. Parents tailor homework to the individual abilities of each young person and tailor the programme suit to that young person's understanding of the concepts.

4. Teacher aides respond to the needs of the child 'on-the-day' and exercise their judgement as to how the young person or persons they are assigned could learn best in the time available.

When implementing any future training of the 'Healthy Relationships' programme, Kidpower Teenpower Fullpower Trust should be aware of these application styles and attempt to tailor information to these groups based upon the students' abilities in order to apply the programme in the most beneficial way.

8 Recommendations for future evaluations

8.1 Add the quantitative using tested measures

A quantitative analysis of any subsequent programme's outcomes will also need a similar in-depth involvement of evaluation staff to ensure rigorous data is collected in a sound and timely fashion.

This can be achieved by bringing quantitative staff on-board prior to the programme roll-out and conducting face-to-face interviews.

Accordingly, Clarity Research recommends during phase two of the 'Healthy Relationships' programme roll out that considerable resources are directed towards ensuring that parents and caregivers are involved and that the survey method is planned and introduced at the beginning, taking account of carer fatigue and information overload.
This can be achieved by having a parent information session at the start where parents could meet Teachers, Kidpower Teenpower Fullpower Trust staff, and evaluators in order to achieve the goals of the roll-out of the programme.

8.2 Operationalising significant change for quantitative outcomes measurement.

As mentioned by parents, teachers, teaching management, teacher aides, and residential care workers not all young people with intellectual disability, scholastic impairment, or developmental delay are able to demonstrate that they have learned any of the behaviours as a result of the 'Healthy Relationships' programme. This is due to these young people having no capacity to express themselves due to their intellectual disability, scholastic impairment, or developmental delay.

This has implications for how future evaluations will need to operationalise the construct of 'demonstrating meaningful change' and the construct of 'displaying evidence of learning', as this was clearly difficult to observe or measure in some of the young people who participated in this programme.

In particular, future implementation of any evaluation will need to be conducted in a way that takes account of the significant minority of individuals who are unable to display changes. This may need to include a justification for the stated percentage of individuals for whom it is anticipated that they will not be able to show evidence of change. This will enable Kidpower Teenpower Fullpower Trust to put any future findings and evaluation activity in context.

9 Summary and Conclusions

‘Healthy Relationships’ programme has produced significant benefits for many of the young people with intellectual disabilities that have attended the programme. Most of the people interviewed were full of praise for the benefits of the programme: “it’s the shiniest tool in my cupboard because it is used most often”; “this programme is brilliant”; “100% of my students have shown improvement”. Teachers were also able to report many specific instances were violence had been averted, abuse had been reported, and dangerous behaviours reduced, which they attributed to the students involvement in the ‘Healthy Relationships’ programme.

However, some young people are simply not able to learn appropriate behaviours and others are unable to show behaviours or verbalise sufficiently well to show that the programme has been of benefit. Despite this, teachers reported that 100% of the students in the programme had displayed at least some small level of improvement over the short time it has been rolled out.

Some of the participant groups in this evaluation were less able to report changes than others; specifically residential care workers and parents/caregivers. Both these groups, along with the teacher aides to a lesser extent, claimed to have limited knowledge about the ‘Healthy Relationships’ programme and what changes to expect. Irrespective of this, these groups were impressed with what they had seen of the programme. Kidpower Teenpower Fullpower Trust would benefit from further coordinating and expanding the teaching of the theoretical background of the programme to all stakeholders that interact with these young people. Kidpower Teenpower Fullpower Trust will also be better able to answer the question “does it work” after a decent period of time has elapsed for the programme to be embedded with these young people.

10 Reference

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11 Annex I – Consent Form

Clarity Research Limited I 510 Armagh Street I Christchurch 8011 I T: (03) 3890 942 I M: 021 1175 609
w w w . c l a r i t y r e s e a r c h . c o . n z

Consent Form

Title: Action on Sexual Violence Primary Prevention for Special Needs Youth

Principal investigators: Dr Mark Turner, Bryce Hamilton, Clarity Research Limited

I have read and understood the information provided about this project in the Information Sheet.

I have had an opportunity to ask questions and to have them answered.

I understand that notes will be taken during the interview and that it will also be audio-taped and transcribed.

I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

I agree to take part in this project.

My signature below indicates that I have read and understood this consent form and that I have agreed to complete the interview.

Participant's signature: .....

Participant's name: .....

Date: .....

Note: The Participant should retain a copy of this form.
This research operates under the research ethics protocols of the Australasian Evaluation Society (AES) Guidelines for the Ethical Conduct of Evaluations. These guidelines may be accessed at: http://www.aes.asn.au/about/Documents%20-%20ongoing/guidelines_for_the_ethical_conduct_of_evaluations.pdf

Any questions or complaints can be forwarded to Clarity Research Limited.

12 Annex II

Clarity Research Limited I 510 Armagh Street I Christchurch 8011 I T: (03) 3890 942 I M: 021 1175 609
w w w . c l a r i t y r e s e a r c h . c o . n z

Information Sheet

Title: Action on Sexual Violence Primary Prevention for Special Needs Youth

Principal investigators: Dr Mark Turner, Bryce Hamilton, Clarity Research Limited

This interview is being undertaken as part of the evaluation of *Action on Sexual Violence Primary Prevention for Special Needs Youth*. 'Kidpower Teenpower Fullpower Trust' have engaged 'Clarity Research Limited' to evaluate this programme.

This phase of the evaluation will involve individual open ended interviews with key informants to establish what changes have been observed in young people with special needs who have been through the programme.

What will happen?
The intent of this interview is to gain understanding of the impact of *Action on Sexual Violence Primary Prevention for Special Needs Youth* to reduce sexual exploitation and abuse of young people with developmental Special Needs. Interview questions will revolve around your perceptions of what effect, if any, the programme has had on the young people in your care.

The interviewers will take notes of the discussion, and although participants' professions may be revealed in subsequent research publications and reports, no quotes or attributed opinions will be used without express permission by the interviewee. Given permission, interviews will also be recorded to back up any written notes. You may refuse to answer certain questions, withdraw from the interview at any time, or request that material not be used.

Confidentiality

- What you say will be confidential to Mark and Bryce
- Any information obtained in connection with this project and that can identify you will remain confidential. It will only be disclosed with your permission, *subject to legal requirements*.

How do I agree to participate in this study?
Please take some time to think about whether you wish to be involved with this group. If you are happy to take part, you will sign a consent form that confirms that you understand the information outlined in this document.

Whom do I contact for further information about this research?
If you have further questions about this interview, contact Mark Turner at Clarity Research Limited,

510 Armagh Street, Christchurch 8011 or Phone (03) 3890 942.

This research operates under the research ethics protocols of the Australasian Evaluation Society (AES) Guidelines for the Ethical Conduct of Evaluations. These guidelines may be accessed at: http://www.aes.asn.au/about/Documents%20-%20ongoing/guidelines_for_the_ethical_conduct_of_evaluations.pdf