STATEWIDE POLICY & COLLABORATION PROPOSAL

THE COMPASS & SHIELD COALITION

Founded by Brianna Green

Advocating for inherent dignity, vigilant protection, and equal rights in New Jersey public schools

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A POLICY PROPOSAL INFORMED BY DISABILITY-ABUSE RESEARCH

THE INVITATION

This movement began with one child, but it belongs to thousands. The Compass & Shield Coalition is bringing parents, educators, clinicians, attorneys, health professionals, policy leaders, and community advocates together to build a practical statewide safeguard for children who require intimate care at school.

Our purpose

The coalition proposes a clear, written intimate-care safeguard policy for every child who needs toileting or changing assistance, whether the child has an IEP, a Section 504 plan, is still being evaluated, or has no formal disability plan yet. We are recruiting a multidisciplinary working group to examine the proposal, strengthen its legal and clinical foundation, and develop an implementation model that New Jersey districts can use.

What the evidence shows

KEY FINDING	RESEARCH RESULT	SCOPE
2.88× odds	Children with disabilities had 2.88 times the odds of sexual violence compared with children without disabilities. Pooled prevalence: 13.7%.	Systematic review; 17 studies; 18,374 children.[1]
2–3× risk	Children with autism plus intellectual disability and children with intellectual disability alone were two to three times more likely to experience maltreatment than controls.	U.S. population-based record-linkage study; 4,988 children.[2]
Disclosure barriers	Federal guidance identifies lack of language to disclose, dependence on caregivers, isolation, and skepticism about credibility as vulnerabilities.	U.S. DOJ/OJJDP forensic-interview guidance.[4]

Important limitation: research does not provide a reliable, separate prevalence rate specifically for non-speaking autistic children. The communication and caregiver-dependence risks are established, but a precise subgroup percentage should not be invented.

THE VISION OF THE VILLAGE

A Universal Call to Action

The inspiration: why we fight

This movement began with my son, a child with Level 3 autism who requires very substantial support. Every day, he teaches me what resilience looks like. He also reminds me that children who cannot independently protect their privacy or report a concern rely on the systems adults build around them. Their dignity and safety cannot depend on chance, informal custom, or whichever employee happens to be available.

The truth: advocacy takes a village

A parent can sound the alarm, but durable reform requires collective expertise. No single profession holds the entire solution. The strongest policy will be built by people who understand child development, disability communication, intimate care, school operations, public health, civil rights, workforce realities, and implementation.

> MY REQUEST
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> **I am asking you to be part of that village: to examine the problem honestly, contribute the expertise you hold, challenge what needs refinement, and help transform a parent's concern into a credible and workable statewide safeguard.**

The pre-IEP/504 safeguarding gap

Children with significant developmental and communication needs may require toileting or changing support from the first day they enter school. Yet an individualized IEP or Section 504 plan can take time to evaluate, develop, and finalize. A child's need for privacy, sanitation, predictable care, communication access, and physical safety exists during that waiting period—not only after paperwork is complete.

Without an interim standard, districts may rely on rotating or undefined staff, inconsistent procedures, and undocumented care. That ambiguity can create distress for the child, increase hygiene and cross-contamination concerns, leave staff without clear boundaries, and expose districts and families to preventable conflict.

The coalition's starting principle

Every student who requires intimate care should receive immediate baseline protections at enrollment. An individualized educational plan may add detail, but it should not be the event that first creates bodily dignity, staff accountability, and a safe care process.

THE STARTING FRAMEWORK

The Tri-Pillar Shield Protocol

A proposed model for multidisciplinary review—not a claim that these measures are already mandated by New Jersey law

1

Designated Intimate-Care Teams

Limit toileting, diapering, wiping, and changing assistance to a small, familiar, trained, and preauthorized group. Establish primary and backup assignments so predictable care does not collapse when one person is absent.

2

Two-Adult Accountability Standard

Evaluate a two-adult safeguard for intimate-care events. The working group should determine when both adults must be physically present, when one may remain immediately available, and how to preserve the child's privacy while protecting children and staff from unmonitored or disputed encounters.

3

Secure Accountability Logging

Create a secure, time-stamped record of each care event, including the staff involved, care provided, any deviation from the plan, the child's observable distress or refusal, and any visible redness, irritation, rash, bruising, bleeding, swelling, broken skin, or other unusual finding. Record who received the internal report and whether authorized notification was required. Access, retention, and confidentiality rules must be defined.

An open call for collaborative expertise

- **Legal professionals and attorneys:** fortify civil-rights protections, identify legal gaps, and evaluate liability and records issues.
- **Nurses and public-health professionals:** validate hygiene, infection-control, objective observation and escalation, and staff-training standards, including which health and workplace rules apply.
- **Teachers, paraprofessionals, and administrators:** test staffing, scheduling, privacy, substitute, and documentation procedures against real school operations.
- **BCBAs, OTs, SLPs, PTs, and other clinicians:** integrate sensory regulation, transfer safety, functional communication, assent, refusal, and behavioral baselines.
- **Parents, disability advocates, and community leaders:** center lived experience, identify inequities, build public understanding, and carry the framework to boards and legislative offices.

WHAT MEMBERS WILL DO

Review and improve the draft • Identify governing standards • Recommend practical safeguards • Test feasibility • Help present a unified proposal to New Jersey education and policy leaders

THE PROPOSED POLICY

Required Safeguards for Intimate Care

A district-wide minimum standard for toileting, diapering, changing, and related personal care

1 — Authorized personnel

Use a limited, identifiable pool of trained primary and backup staff. A substitute process must be defined in advance; care should not default to any employee who happens to be available.

2 — Individualized written plan

Develop the plan with the parent or guardian. Identify the child's assistance, hygiene, positioning, sensory, medical, behavioral, and communication needs.

3 — Privacy and bodily dignity

Provide an appropriate private setting, explain each step in the child's accessible communication mode, minimize exposure, and preserve dignity throughout care.

4 — Communication and refusal

Keep AAC or other communication available. Teach and recognize the child's signals for stop, help, pain, discomfort, refusal, and distress; never treat non-speech as non-communication.

5 — Objective care documentation

Record the date, time, reason, authorized staff involved, care provided, any deviation from the plan, the child's observable distress or refusal, and any visible redness, irritation, rash, bruising, bleeding, swelling, broken skin, or other unusual finding. Nonclinical staff document what they observe without making a medical diagnosis.

6 — Internal reporting and authorized notification

The staff member providing care must immediately report concerns or deviations to the designated supervisor and, when appropriate, the school nurse. The designated administrator or nurse—not the care provider—is responsible for promptly notifying the child's parent, legal guardian, or other authorized contact and documenting when and how notice occurred. This process does not replace emergency-response or mandated-reporting duties.

7 — Training and reporting

Require training in disability communication, boundaries, abuse prevention, mandated reporting, trauma-informed care, and the child's individualized baseline.

8 — Supervision and review

Identify who reviews care records, how concerns are escalated, how families obtain records, and how the plan is reviewed and updated.

POLICY PRINCIPLE

Children who require intimate care deserve the same procedural clarity schools apply to medication, transportation, arrival and dismissal, and authorized pickup.

EVIDENCE & APPLICATION

Why This Policy Is Necessary

Why non-speaking children require deliberate safeguards

- A child may be unable to make a conventional verbal disclosure even when the child communicates through AAC, gestures, behavior, facial expression, movement, or other individualized methods.
- Dependence on adults for intimate care creates unavoidable one-to-one access to private body areas. Clear procedures protect both the child and responsible staff.
- Behavioral changes, distress, avoidance, regression, or self-injury can be misread as features of disability instead of possible indicators that require observation and follow-up.
- A written policy does not presume misconduct. It closes an accountability gap before harm occurs and makes expectations consistent across children, classrooms, and staff changes.

Proposed statement to decision-makers

BRIANNA'S POSITION

I am not alleging that any staff member intends to harm my child. I am identifying a safeguarding gap. My child is non-speaking, depends on adults for intimate care, and may not be able to make a conventional verbal disclosure. Research shows elevated abuse risk among children with disabilities, while federal guidance identifies communication barriers and caregiver dependence as specific vulnerabilities. Dignity and safety therefore require a written policy identifying authorized staff, training, procedures, documentation, communication access, supervision, and accountability.

Cited sources

1. Jones, L., Bellis, M. A., Wood, S., et al. (2012). Prevalence and risk of violence against children with disabilities: A systematic review and meta-analysis of observational studies. The Lancet, 380(9845), 899–907. https://doi.org/10.1016/S0140-6736(12)60692-8

2. McDonnell, C. G., Boan, A. D., Bradley, C. C., Seay, K. D., Charles, J. M., & Carpenter, L. A. (2019). Child maltreatment in autism spectrum disorder and intellectual disability: Results from a population-based sample. Journal of Child Psychology and Psychiatry, 60(5), 576–584. https://doi.org/10.1111/jcpp.12993

3. Trundle, G., Jones, K. A., Ropar, D., & Egan, V. (2023). Prevalence of victimisation in autistic individuals: A systematic review and meta-analysis. Trauma, Violence, & Abuse, 24(4), 2282–2296. https://doi.org/10.1177/15248380221093689

4. U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. (2022). Interviewing Children with Disabilities: A Practical Guide for Forensic Interviewers. https://ojjdp.ojp.gov/publications/interviewing-children-with-disabilities

Interpretive cautions

- The 13.7% prevalence and 2.88 odds estimate apply to children with disabilities broadly, not only autistic or non-speaking children.
- The autism-specific meta-analysis reported high variation across studies and combined ages; its 40% sexual-victimization estimate should not be described as a child-only rate.
- Maltreatment includes sexual, physical, and emotional abuse and neglect. Overall maltreatment findings should not be converted into a sexual-abuse percentage.
- Elevated risk does not imply that a particular staff member is unsafe. It supports reasonable, documented prevention and accountability procedures.

BUILD THE SHIELD WITH US

A Charter of Collaboration & Recognition

A shared reform requires shared ownership

The Compass & Shield Coalition is not asking professionals to endorse a finished product without question. We are inviting them to help build the product: to examine the evidence, identify weaknesses, improve safeguards, and create a model that protects children while remaining lawful, respectful, and workable for school communities.

How contributors will be recognized

- **Document attribution:** With permission, substantive contributors will be listed in a “Contributors and Reviewers” section with their name, professional title, organization, and defined role. Attribution will reflect actual participation and will not imply organizational endorsement unless authorized.
- **Public acknowledgment:** When the proposal is presented publicly, participating steering-committee members may be acknowledged in testimony, presentation materials, or meeting records with their consent.
- **Professional contribution letter:** Contributors may receive a letter documenting the scope of their volunteer research, review, drafting, clinical, legal, operational, or advocacy contribution.
- **Continuing voice:** Members will be invited to participate in revisions, pilot discussions, public education, and future presentations consistent with their expertise and availability.

Coalition commitments

- Children's dignity and safety remain the central measure of every recommendation.
- Professional feedback will be represented accurately; credentials and affiliations will never be used without permission.
- Draft proposals will clearly distinguish confirmed legal requirements, recommended best practices, and policy ideas still under evaluation.
- The coalition will seek practical input from the people expected to implement the policy, including paraprofessionals, nurses, teachers, administrators, clinicians, and families.
- Disagreement will be treated as part of responsible policy development, not as disloyalty to the mission.

JOIN THE WORKING GROUP

We are seeking New Jersey parents, attorneys, nurses, educators, paraprofessionals, administrators, BCBAs, OTs, SLPs, PTs, public-health professionals, disability advocates, policy specialists, and community leaders. To express interest, contact Brianna Green at brianna.m.green@outlook.com and briefly identify your professional background, organization (if applicable), and the perspective or expertise you would like to contribute.

A final word from Brianna

A single mother can identify the gap. A village can build the safeguard. If we combine lived experience with legal, clinical, educational, and operational expertise, we can create a standard worthy of the children who depend on us. I am asking you to be part of that village.