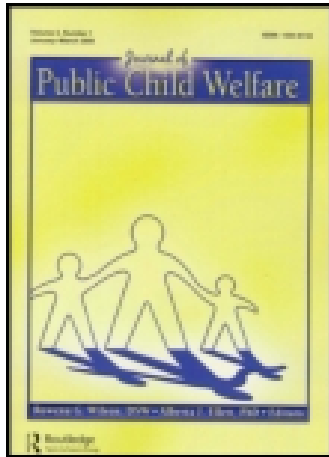


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Implementation of an Intensive, Home-Based Program for Parents With Intellectual Disabilities

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This article describes retrospective findings from a parenting program developed in collaboration with a local Department of Social Services for adults with intellectual disabilities to increase parenting skills. Program intervention consisted of home-based services offered three times a week over the course of four to six months, focusing on a variety of topics including child development, planning/problem solving, and childcare. Post-intervention outcomes are reported for approximately 50 families. Significant increases were found in the percentages of eight of 10 observable parenting skills and in the quality of the home environment. Additional factors of interest noted were characteristics regarding parents with intellectual disabilities. Findings support consideration of wider applications of targeted, home-based services for parents with intellectual disabilities.

KEYWORDS *child maltreatment, child protection, policy issues, family preservation*

Historically, the notion of individuals with intellectual disabilities taking on parental roles was perceived as unfeasible or unlikely. However, with the increasing integration of adults with intellectual disabilities into communities, more people with intellectual disabilities are becoming parents (Tarleton & Ward, 2007; Willems et al., 2007). Concomitant with this increase is a growing concern that parents with intellectual disabilities are becoming disproportionately involved with the child welfare system (Booth, Booth, & McConnell, 2005a; McConnell et al., 2011; McConnell, Llewellyn, & Ferronato, 2006). The

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increasing number of adults with intellectual disabilities who are becoming parents, the effects of possible abuse/neglect and child welfare reports, and the financial impacts of involvement with the child welfare system, highlights the necessity of bringing more awareness to the specialized needs of this population and available services. This article evaluates one such service, a specialized parent education program developed six years ago with support from a local child welfare agency.

BACKGROUND

While there have been efforts internationally to estimate the prevalence of parents with intellectual disabilities (Booth et al., 2005a; McConnell et al., 2011; Pixa-Kettner, 2008; Willems et al., 2007), efforts in the United States are limited. The two national studies of prevalence are an analysis using the Disability Supplement of the National Health Interview Study conducted in 1994/1995 (Anderson et al., 2005), which found approximately 200,000 mothers with intellectual disabilities in the United States, and a more recently completed analysis of the 2010 American Community Survey, which estimated that 2.3% of American parents have intellectual disabilities (Kaye, 2012). There is also limited data on parental disability at the local level in the United States due to a combination of factors including variable definitions of an “intellectual disability,” limited recognition that parents with intellectual disabilities are present in communities, and inconsistent organizational practices regarding identifying and gathering data on the numbers of parents with intellectual disabilities. While data on child welfare involvement is limited regarding parents with disabilities in the United States, international reports suggest that parents with disabilities are disproportionately involved in the child welfare system (Booth et al., 2005a; McConnell et al., 2011). Indeed, 37 states in the United States include disability-related language, such as mental retardation, as a possible grounds for the termination of parental rights (Lightfoot, Hill, & LaLiberte, 2010). Thus, there are concerns that children of parents with intellectual disabilities could be at a particular risk for out-of-home placement (Booth, Booth, & McConnell, 2005b).

While parents with intellectual disabilities might not be more likely than the general population to purposely maltreat their children, they could struggle with abstract thinking, problem solving, and generalization tasks, all of which are necessary for parenting (Feldman, 2002). Parents with intellectual disabilities are also at increased risk for having children with their own intellectual, educational, and behavioral needs, which may pose an additional parenting challenge (Faureholm, 2010; Feldman, 2002; Keltner, Wise, & Taylor, 1999; McConnell et al., 2008; McGaw, Scully, & Pritchard, 2010) and heighten risk for abuse and neglect.

Parents with intellectual disabilities are also reportedly at risk for higher levels of parental stress (Aunos, Feldman, & Goupil, 2008; Feldman, 2002), as well as increased social isolation (Baum & Burns, 2007; Mayes, Llewellyn, & McConnell, 2008; Willems et al., 2007). Both can then place parents with intellectual disabilities at a higher risk for parenting difficulties and potential child maltreatment (Aunos et al., 2008; Feldman, 2002; Willems et al., 2007). Inaccurate assumptions that intelligence automatically reflects parenting ability also contributes to the disproportionate representation (McConnell et al., 2006).

Child welfare involvement can elicit feelings of confusion, intimidation, grief, blame, and helplessness in all parents, including parent with intellectual disabilities (Baum & Burns, 2007; McConnell & Sigurjonsdottir, 2010). The financial impact on communities is also significant. In 2010, at least \$29.4 billion was spent in local, state, and federal funds for child welfare purposes, which includes foster care and case management supports (De Vooght et al., 2012). The amount does not take into account the additional costs subsequently incurred from providing intervention through additional systems, such as the mental health and criminal justice systems, necessitated by the developmental and behavioral impacts of child abuse and neglect (Gelles & Perlman, 2012).

The limited literature on the topic of parents with intellectual disabilities primarily focuses on whether this population of adults can adequately and safely parent. Increasingly the literature is focusing on raising awareness of the types of protective factors—such as parent training and social supports—that can help individuals with intellectual disabilities be successful in their roles as parents (McConnell et al., 2008). There is now emphasis on the parental support needs of parents with disabilities in addition to their individual support needs (Lightfoot & LaLiberte, 2011). This, in turn, may eliminate their over-representation in the child welfare system (McConnell et al., 2011).

Currently, there is limited support available for parents with disabilities. While parents with intellectual disabilities may qualify for supports through disability specific agencies, such agencies are typically geared towards providing housing, vocational, and service coordination supports. Rarely do disability agencies provide parenting support to parents with intellectual disabilities. Parents can also access support through traditional parenting programs. However, a typical parenting curriculum typically does not effectively address the specific needs of parents with intellectual disabilities, as the curriculum is often too complex and the length of services too brief. Programs that provide specialized support for parents who have an intellectual disability are becoming a growing focus of international attention (McConnell et al., 2008; Tarleton & Ward, 2007). Successful programs are home-, skill-, and behavior-based, individualized, and coordinated with other services (Feldman, 2010; Wade, Llewellyn, & Matthews, 2008). Specific strategies for

teaching include visual supports, modeling and role-playing, and positive reinforcement (Feldman, 2010). Programs typically focus on the domain of basic childcare and/or home and health safety skills (Feldman, 2010; Tymchuk, 2006; Wade et al., 2008).

While there is a growing international focus on parent training, there has been a more limited focus in the United States. This study fills this gap by assessing the effectiveness of an intensive, home based program, funded through collaboration with a local child welfare agency, on parent and home functioning.

METHOD

This study involved a retrospective records review of pre-post intervention data that were collected during implementation of a home-based parent skills training program, Project IMPACT. Instruments were completed throughout the program in order to: (a) track parent functioning, (b) provide feedback regarding client functioning to DSS, and (c) monitor program effectiveness. Assessments consisted of both parent questionnaires and observational measures.

Intervention

Project IMPACT was created by the Westchester Institute of Human Development in Valhalla, New York, in 2006 with collaboration and funding through the Westchester County Department of Social Services (DSS) in order to provide a combined safety and skill based curriculum to parents who have intellectual disabilities or learning difficulties and are involved in the child welfare system, at risk for family disruption. The primary purpose of the program was to provide specialized parenting supports to parents with intellectual disabilities.

In-home services were provided to each family by a master's level social worker in 1- to 1.5-hour sessions, three times a week, for 4 to 6 months. Intervention consisted of verbal instruction, clinician modeling, videos, pictorially based handouts, and hands-on practice. Visual handouts included home illustrations from the UCLA Parent-Child Health and Wellness Project (Tymchuk, 2006) and hands-on practice included role-playing with the clinician and, when helpful, utilizing dolls to practice skills, such as diaper changing. Skills were also demonstrated *in vivo* with the children in the family and encouraged during community visits with the clinician (e.g., at physician's appointments and school meetings). As an example, a trip to the grocery store involved a review of planning (identifying what groceries were needed), budgeting (identifying how much money could be and was spent), and nutrition (identifying healthy meal options). Eight main topic

areas were covered (parent/child interaction skills, basic child care, child development, home/health safety, home management, parent advocacy, and planning/problem-solving skills) and consisted of approximately 25 individual skills, including limit setting, hygiene routines, age-appropriate social skills, and medical advocacy.

Skills were covered over the course of 1 to 3 weeks, and then reviewed again as needed throughout the program, as well as prior to the conclusion of services. Portions of the curriculum were individualized to accommodate a family's particular strengths and needs, and the age of their children. Supplies to support skills development, such as accordion folders to organize a family's medical records, and incentives, such as gift cards, were provided throughout.

Participants

For this article, data are reported on the 50 families who fully participated in Project IMPACT from 2006 to 2012. Data on the additional 22 families whose program involvement ended early were not included, as the majority of these families ended in less than 1 month's time, due to various factors including substance abuse needs and reluctance to participate in an intensive level of services. All referrals originated from the local DSS for families where there was an open Preventive Services (PS) case due to one or more reports of suspected child maltreatment. Parents (M = age 33 years; range = 20–50 years) were eligible for program participation if they presented with an IQ score of 80 or under (with 100 representing the average IQ score) and/or a history of significant learning difficulties, which is criteria often used in work with this population of parents (Mayes et al., 2008). Average Full Scale IQ score for this group of participants was noted to be 65 (range = 44–84), based on either prior documented testing or completion of a brief cognitive screener. IQ was not available for seven parents; however, program eligibility was established as they had documentation of a formal intellectual disability diagnosis. Parents were English-speaking, Spanish-speaking, or bilingual. Parent race/ethnicity was Black (50%), Hispanic (32%), and White (18%). Seven parents were fathers; the remaining were mothers. Parents had co-occurring mental health needs (60%), domestic violence needs (46%), or both (40%). Ninety six percent of parents were concurrently involved with up to six other services (e.g., mental health); however, only 14% received formal disability services. Of the parents, 64% had prior parenting program involvement, but were subsequently referred for this particular program due to concerns that limited change in functioning had been noted. The 50 families had a total of 107 children, with one to seven children per family, ranging in age from infancy to 17 years old (M = age 6 years). Of the children, 49% had a documented disability or delay.

Instruments

DEMOGRAPHICS AND CHILD CHARACTERISTICS

Demographic data on parents and children were gathered through review of intake information. The *Vineland Adaptive Behavior Scale, Second Edition (Vineland-2)* (Sparrow, Balla, & Cicchetti, 2005), completed through parent interview at the start of services, was used to gather information on child characteristics. The *Vineland-2* measures adaptive functioning across the domains of communication, daily living, and socialization, as well as motor skills for children younger than age 7 years.

HOME ENVIRONMENT

The quality of the home environment was gathered via the *HOME Inventory* (Caldwell & Bradley, 1984), which has been used with this particular population of parents (Aunos et al., 2008; Mildon, Wade, & Matthews, 2008). This observationally based measure explores a variety of characteristics, including parental acceptance of child behavior, opportunities for developmental stimulation, and the physical environment of the home. All four versions of the inventory (infant/toddler, early childhood, middle childhood, and early adolescent) were utilized, depending on the particular age of the children in the home. To allow for comparison of scores across age groups, all raw scores were converted to percentages based on the total possible score for each version. Checklists were completed at intake and discharge.

PARENT FUNCTIONING

Parent functioning was assessed at intake and discharge, with the *Parenting Stress Index (PSI)* (Abidin, 1995). The *PSI Short Form* consists of 32 items based on a 5-point Likert scale and yields findings in three sub-domains, as well as one overall domain. The measure explores stress level as it relates to the parental role, including personal factors related to parenting, parental perception that children do not meet their parent's expectations, and challenging behavioral characteristics of children. Although it has been designed for parents with at least a fifth grade educational background, it has been used in studies involving parents with intellectual disabilities (Aunos et al., 2008). Parents were given the option to complete the questionnaire independently or have items read to them by the clinician.

The *Child Abuse Potential Inventory (CAPI)* (Milner, 1986) was also completed at intake and discharge to assess intervention effectiveness. This 77-item measure consists of six factor scales, exploring such variables as feelings of unhappiness and difficulties in relationships, as well as one overall abuse scale. The overall abuse scale examines parental responses in the context of others who have a history of child physical abuse. The readability

level of the measure has been identified at a third grade level. Parents were given the option to complete it independently or have items read to them.

Given that one of two primary goals of the program is to increase parenting skill levels, specific parenting skill attainment was measured through clinician-based, objective observations at intake and discharge, as well as a week after a skill was taught (i.e., following skills training). For example, for the skill of providing praise, the clinician documented via checklists why (due to a specific behavior), how (with eye contact and positive tone of voice), and when (immediately after a behavior) a praise statement was made. Scoring of each item was based on whether it was observed/not observed or present/not present. The exception to this was for three of the safety checklists, which were parent-directed questions, asking them to identify responses such as what information would need to be given to a 911 operator. Clinicians were initially trained in the completion of the checklists by the program supervisor, who accompanied them to initial sessions where the checklists were completed. Documentation of concrete skills, such as infant feeding, are loosely based on those created by Feldman and Case (1993). A total of 14 checklists were completed with all clients and then grouped into five categories (child cleanliness, home management, parent/child interaction, planning, and safety) for analysis. An additional nine checklists were optionally completed if appropriate for the age of the particular children in the home. For the purposes of analysis, all infant childcare skills (such as diapering) were clustered together, and the remaining skills were analyzed independently.

FOLLOW-UP DATA

Three years following the start of services, a 3-month follow-up assessment was added to the program; as such, these data are only available on approximately half of the families. At this follow-up, the following measures were re-administered: the *HOME*, the *PSI*, the *CAPL*, and the skill observation checklists. While descriptive findings from this time period is shared, only limited data were used for exploring significant levels of change given the smaller sample size.

PROGRAM SATISFACTION AND 1-YEAR FAMILY STATUS

Consumer and caseworker satisfaction data were obtained at closing. Clients and their DSS caseworkers were requested to complete satisfaction surveys on their impressions of the program and the parenting clinician who worked with the family, using a two or three choice response scale. Qualitative feedback was also sought. Parents either completed the form alone or with assistance from their DSS caseworker. From 2009, 1-year post-intervention family status (i.e., whether families remained intact and maintained involvement with DSS) was also gathered, at the request of DSS.

TABLE 1 Child Characteristics

Domains	<i>n</i> ^a	%	Domains	<i>n</i> ^a	%
Communication	14	32%	Daily Living	16	36%
Socialization	24	54%	Motor	13	46%
Composite	19	43%		—	—

Note. Vineland Adaptive Behavior Scales, Second Edition (Vineland-2) ($n = 44$).

^aRefers to Moderately Low/Low scores.

Procedures

Following approval from the New York Medical College Institutional Review Board, a retrospective records review of program data were completed. Using SPSS, descriptive statistics were obtained and a series of paired sample *t* tests or repeated measures ANOVAs were conducted to identify significant findings. Parenting services was the independent variable. Dependent variables were level of parental rigidity and stress, quality of the home environment, and parenting skills. Cohen's criteria or partial eta squared were used to evaluate the magnitude of change. Bonferroni's post hoc analysis was completed on significant ANOVA findings.

RESULTS

Child Characteristics

Child characteristics were gathered through review of parent report on the *Vineland-2* (Table 1). Data from three families were not gathered given the young age of the child in the home. Data on an additional three families were missing. Forty-three percent of the children were reported to have “moderately low” or “low” adaptive functioning overall. The highest percentage of children was described as having needs in the socialization domain (54%). Findings were comparable to reports that 49% of the total number of children had a documented diagnosis and/or involvement with early intervention or special education systems.

Home Environment

The mean scores for the *HOME Inventory* at intake, discharge, and 3-month follow up are presented in Table 2. On the *HOME Inventory*, data were incomplete for two families and not used. For the remaining families, significant increases were noted from intake to discharge when combining results across all four age groups, $t(47) = 5.81, p < .001, 95\% \text{ CI } [.08, .17]$. Effect size was found to be $d = .86$. With the 27 participants where follow-up data were available for the *HOME*, a repeated measures ANOVA was also performed. To

TABLE 2 Home and Parent Functioning

Measure	Intake		Discharge		3-month follow-up	
	<i>n</i>	<i>M (SD)</i>	<i>n</i>	<i>M (SD)</i>	<i>n</i>	<i>M (SD)</i>
<i>HOME</i>	48	.56 (.16)	48	.69 (.14)	27	.70 (.17)
<i>PSI</i> ^a	40 ^b	99.50 (29.45)	40 ^b	93.65 (30.09)	23 ^c	93.26 (26.51)

^aClinically significant scores are at or above the cutoff score of 90.

^bTen participants were excluded due to defensive response findings at intake and/or discharge.

^cThree participants were excluded due to defensive response findings at follow-up.

account for violations of sphericity, the Greenhouse-Geisser correction was applied. Significant findings were noted, $F(1.534, 39.97) = 27.58, p = <.001$, with an effect size of .51. Post-hoc analysis revealed significant differences ($p = <.001$) between intake and discharge scores (difference of .17), as well as intake and 3-month follow up scores (difference of .16). From intake to discharge, confidence levels ranged from .098 to .245 and from intake to 3-month follow-up from .087 to .241.

Parent Functioning

The mean scores for the *PSI* at intake, discharge, and at 3-month follow up are presented in Table 2. Although there were pre-post reductions on *PSI* scores, the results were not found to be statistically significant. Similarly, a repeated measures ANOVA using 3-month follow up data was not significant.

Findings from the *CAPI* could not be assessed pre-post intervention given an unusually high number of elevations on the validity scale (82%). Nonetheless, despite a primarily elevated defensive responding style, 66% of 50 parents reported a clinically significant level at intake on the rigidity subscale, the subscale most related to parenting which examines expectations regarding the appearance and behavior of children and the appearance of one's home.

For the four skills checklists (Table 3) that could be completed across all age groups, data were available for all 50 families. Sample size varied for the remaining six checklists that are age-dependent (e.g., infant child care). One-way repeated measures ANOVA's were calculated on skill levels at intake, following skills training (i.e., the week after a skill was taught), and at discharge, with subsequent post-hoc analyses (Table 4). For the skill of planning/problem solving, significant increases were noted from intake to following skills training, following skills training to discharge, and intake to discharge ($F(2, 98) = 33.74, p < .001$). For three of the skills, significant findings were obtained from intake to following skills training and intake to discharge. These skills were home management, ($F(2, 98) = 8.64, p < .001$), parent/child interactions ($F(2, 88) = 7.13, p < .001$), and feeding older child

TABLE 3 Mean Parenting Skills Percentage Across Time

Parenting skill	Intake		Following skills training	Discharge	Effect size	3-month	
	<i>n</i>	%	%	%	η^2_{partial}	<i>n</i>	%
Child cleanliness	50	67%	68%	69%	—	26	63%
Communication	35	49%	63%	60%	.10	19	45%
Feeding older child	38	63%	75%	81%	.23	21	77%
Home management	50	54%	64%	63%	.15	27	58%
Infant child care	30	70%	79%	86%	.20	10	84%
Interaction	45	58%	70%	68%	.14	23	62%
Planning	50	49%	68%	78%	.41	26	77%
Safety	50	82%	85%	85%	—	26	85%
Time out	31	46%	69%	63%	.13	18	61%
Toileting	12	44%	63%	71%	.32	10	70%

($F(1.63, 60.13) = 11.13, p < .001$). Significant findings from only intake to following skills training were observed for two skills, communication ($F(2, 68) = 3.74, p = .04$) and time out ($F(2, 60) = 4.42, p = .02$). A significant finding from only intake to discharge was noted with the skill of infant childcare ($F(1.50, 43.45) = 7.18, p = .004$). An overall significant finding was noted for toileting ($F(2, 22) = 5.29, p = .01$); however, there were no significant differences between any particular time points. No significant findings were obtained for the skills of safety or child cleanliness. To account for violations of sphericity in the feeding older child and infant childcare data,

TABLE 4 Parenting Skills Differences Across Time

Skill/time	Diff	CL	<i>p</i>	Skill/time	Diff	CL	<i>P</i>
Communication				Feeding older child			
I vs. FST	.14	.03, .26	.012*	I vs. FST	.12	.02, .22	.019*
FST vs. D	-.03	-.17, .11	1.00	FST vs. D	.06	-.01, .13	.145
I vs. D	.11	-.05, .28	.253	I vs. D	.17	.07, .28	.001**
Home management				Infant child care			
I vs. FST	.10	.04, .16	.001**	I vs. FST	.09	-.04, .21	.241
FST vs. D	.01	-.07, .05	1.00	FST vs. D	.07	-.04, .18	.419
I vs. D	.09	.02, .16	.009**	I vs. D	.15	.09, .22	<.001***
Interaction				Planning			
I vs. FST	.13	.05, .22	.001**	I vs. FST	.19	.11, .28	<.001***
FST vs. D	-.03	-.12, .06	1.00	FST vs. D	.10	.01, .18	.021*
I vs. D	.11	.00, .21	.044*	I vs. D	.29	.19, .38	<.001***
Time Out				Toileting			
I vs. FST	.23	.05, .40	.009**	I vs. FST	.19	-.06, .44	.163
FST vs. D	-.07	-.28, .15	1.00	FST vs. D	.08	-.10, .27	.669
I vs. D	.16	-.04, .37	.163	I vs. D	.27	-.01, .56	.063

Note. I, intake; FST, following skills training; D, discharge.

* $p < .05$; ** $p < .01$; *** $p < .001$.

TABLE 5 Program Satisfaction

Category	Client surveys (<i>n</i> = 50)		Caseworker surveys (<i>n</i> = 32)	
	<i>n</i>	%	<i>n</i>	%
<i>A lot</i> happy with services	39	78%	31	97%
<i>A little</i> happy with services	10	20%	1	3%
<i>Not at all</i> happy with services	1	2%	0	0%
<i>Would recommend</i> program	49	98%	32	100%
<i>Would not recommend</i> program	1	2%	0	0%

Greenhouse-Geisser corrections were applied for both skills. As depicted in Table 3, effect sizes ranged from .10 to .41, with the largest effect size observed for planning skills. 3 month follow-up data were not analyzed given the variability in sample size across skills.

Program Satisfaction and 1-Year Family Status

A summary of program satisfaction results are presented in Table 5. Data were available from all 50 families, as well as 32 caseworkers. Overall, both parents and caseworkers reported a high level of satisfaction with services offered. Qualitatively, parents provided such feedback as, “She took the time to answer my questions when I did not understand some of the parenting skills,” and “Her empowerment and patience. She motivated me in a positive way and did not make me feel threatened.” A longer length of services, parenting groups, and assistance with housing and job training were identified as additional supports of interest.

Of the 36 families where one year family status was available, 97% remained intact at one year following the conclusion of services. Foster care placement occurred with one family, primarily due to maternal mental health concerns. Of the same families, 24 continued to receive preventive services at 1-year follow-up, while involvement for seven families ended. The status of continued DSS involvement for five families is unknown.

DISCUSSION

This article describes findings from an intensive home-based program for parents with intellectual disabilities where there have been one or more reports of child abuse or neglect. Following implementation of an intensive, in-home based service, improvements were noted in eight of 10 parenting skills areas taught (communication, feeding an older child, home management, infant child care, parent/child interaction, planning/problem solving, time out and toileting). The finding that communication skills and time out skills increased

significantly one week after skills training, but then decreased again slightly by the time of discharge suggests the need for ongoing reinforcement of parent/child interaction skills. Improvements were noted for the skill of toileting overall; however, not necessarily at a particular time point (e.g., intake to discharge), which is likely due to the limited number of families who had a pre-school aged child and thus needed the skill. The two skills not noted to significantly improve were child cleanliness and safety. While we do not know why child cleanliness skills did not increase after the training, limited gains in child cleanliness skills may be related to minimal resources for clothing and toiletries, as well as need for increased focus on reinforcing hygiene routines. Safety skills were already noted to be an area of strength at the start of services, which may stem from the parents' reported prior involvement with other providers where there may have been an emphasis on safety, a natural primary area of focus for families with a report of child maltreatment.

An additional important finding is that in-home services can assist in improving the quality of age-appropriate home environments for children of parents with intellectual disabilities. Three-month follow-up data on the home environment were limited, but also significant, which holds promise for potentially longer-term retention of skills. Consumer and caseworker satisfaction was quite positive, which is consistent with prior literature that parents appreciate support when it is offered (Tarleton & Ward, 2007).

The inability to use *CAPI* findings due to an elevated percentage of invalid responses highlights the necessity of developing maltreatment-related measures that are specific for individuals with intellectual disabilities. While parents may have attempted to present themselves favorably due to their involvement with a child protection agency, the unusually high percentage of defensive responses suggests that invalid findings may have also resulted from misinterpretation of items, particularly those with absolute phrasing such as, "Children should stay clean," which is consistent with parent report that items were difficult to understand. Despite this need to present well, the elevated rigidity scores suggest parents with intellectual disabilities may present with a high level of unrealistic expectations of their children, related to a concrete thinking style and limited understanding of age-appropriate child development.

Unlike previously reported findings (Aunos et al., 2008), the participants in this program endorsed a stress level above the clinically significant cutoff. A non-significant decrease on the *PSI* may, in part, reflect the numerous external stressors faced by parents, including economic and housing needs, as well as limited coping resources, which parents with intellectual disabilities may find difficult to separate from feelings specific to parenting stress.

Information noted regarding parent and child characteristics is consistent with the literature. Consistencies included reports of elevated parental stress and a co-occurrence of parental mental health needs (Aunos et al., 2008; Mc-

Gaw et al., 2010). Also similar to previous findings in the literature (Anderson et al., 2005; Keltner et al., 1999; McGaw et al., 2010), children were noted to have special needs. Specifically, in this program, approximately half of the children reportedly had developmental delays and/or special need supports. A characteristic not previously noted was the limited amount of parents with intellectual disabilities formally involved with disability services. This may be due to stigma-related reluctance to identify with disability services (Feldman, 2002) and/or parents falling into the “borderline” range of intellectual functioning, making them ineligible for disability resources. The observation regarding a low out-of-home placement one year post-intervention should be investigated to explore if there is a relationship between intensive services and long-term family status.

Limitations

The findings presented are restricted to those gathered from a review of parents who participated in a specific program and who had prior involvement with DSS. Exploring parents in a prospective based study, particularly prior to child welfare involvement, would be ideal and would allow for potentially more generalizable findings, particularly for those parents who do not rely on significant community support. Limited data restricted the ability to fully analyze 3-month findings. Follow-up data on families who did not complete the program, as well as data from a no-treatment comparison group, would have also been beneficial for comparison. Although some standardized measures reported low reading levels, none were specifically designed for adults with an intellectual disability. This finding, coupled with variability in test administration, likely impacted results. Client confidentiality and clinician-client rapport limited opportunities to assess for clinician fidelity to the curriculum and interrater reliability in the assessment of skills attainment. Finally, simultaneous involvement in other services may have confounded intervention effectiveness.

CONCLUSION

Despite noted limitations, the review of data produced positive findings and contributes towards better understanding specialized, in-home supports to this population of parents. In the United States there are limited, documented programs that offer the intensity of services that Project IMPACT provides. Services are offered at a less intensive level, such as once or twice a week, and are primarily based outside of the United States (Mildon et al., 2008; Wade et al., 2008). Additional features of this program include a comprehensive focus across skill areas and close collaboration with a local child welfare agency. Effects of intervention on home functioning and a larger sample size

than typically seen in documented interventions for this population are also contributions (Wade et al., 2008).

Concern that parents with intellectual disabilities are over-represented in the child welfare system supports consideration of wider application of such targeted interventions as the one described in this article. Future exploration is needed in regards to the sustainability of parenting skill attainment over longer periods of time, as well as comparison of outcomes to non-intervention groups. Efforts are also needed to develop standardized assessment measures that can meet the learning needs of this specialized population.

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