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# Parental Cognitive Disabilities and Child Protection Services: The Need for Human Capacity Building

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*Theories regarding the social cognitive origins of parenting risk have recently emerged. This work not only has implications for the nature of interventions with parents, but also for the approaches taken by the social service systems that work with them. This paper reviews the evidence that there is a significant number of parents with cognitive disabilities within child protection caseloads and outlines the types of human capacity building and organizational development that are needed to support the parents' needs. Such capacity building will not only increase the effectiveness of child protection interventions with parents with cognitive disabilities (PCD), but will also attend to the support and training needs of the professionals who work with them. Capacity building for work with PCD goes beyond the typical training provided in social work programs by including developmentally sensitive intervention techniques and greater linkages with systems outside of child protective services.*

*Key words: Child Protective Services; intellectual disabilities; mental retardation; parenting; staff training*

Our nation's child protective services (CPS) systems are charged with the task of preventing and remediating parental difficulties that affect families who enter their purview. In 2007,

3.8 million children received preventative services and over 1 million received post-investigative services (Administration for Children, Youth and Families [ACYF], 2007). CPS workers are given the responsibility of determining child safety, communicating system mandates to parents and collaborating with them to plan reparative services they will need to retain custody of their children. The task is extremely demanding and failures are often highlighted by the public at large.

Worker recruitment, burnout, turnover, and retention have been the topic of much concern (Curry, McCarragher, & Dellmann-Jenkins, 2005; Savicki & Colley, 1994). Workers' sense of preparedness and efficacy have been cited as factors. Although arguments can be made for hiring social workers with advanced degrees in social work as a solution (Rittner & Wodarski, 1999), we will argue that more focused training, outside of what is currently in the general social work domain, in combination with ongoing consultation, may be needed. This training should emphasize the capacities needed to effectively support the special populations of parents that CPS confronts. These populations may not be responsive to the typical crisis-oriented services provided and thus may account for the repeated involvement of some cases in the CPS system (e.g., chronic neglect cases use up to nine times the service dollars in the system) [Loman & Siegel, 2006]. Based on our theorizing and that of others regarding the role of cognitive processes in parenting risk (Azar & Twentyman, 1986; Azar & Weinzierl, 2005; Crittenden, 1993; Milner, 2003), one can assert that a number of these chronic cases involve parents with cognitive disabilities (PCD). Because cognitive disabilities can include problems with attention, risk assessment, perspective taking, planning, frustration tolerance, and trial and error learning, they would explain the chronic day-to-day difficulties in care giving seen in neglect cases (e.g., failure to monitor, poor medical care and hygiene, inconsistent school attendance). Indeed, in one prospective study, maternal self-reports of "trouble learning" were found to predict later neglect (Slack, Holl, McDaniel, Yoo, & Bolger, 2004). We will further argue that cognitive disabilities that remain unidentified and that do not trigger a shift in workers' approach (i.e., accommodation to different learning styles of parents) can also negatively affect parental capacity to

participate in decision-making and to comprehend responses required of them. Together, these will limit parents' ability to benefit from the traditional manner in which CPS services are provided, and such failure is grounds for termination of parental rights.

This paper will discuss ways to build human capacity within the CPS system in order to provide necessary accommodations for PCD so they may maximally benefit from services and ways to improve providers' sense of preparedness and efficacy. We will discuss cognitive disabilities and why specific efforts are needed to address the needs of this population within CPS. We then argue for specific systemic capacity building to improve caseworkers' and other service providers' skills in working with PCD and linkages with formal and informal supports required for this population.

### CPS Involvement and Cognitive Challenges: A Hidden Issue

The exact number of PCD in the CPS system is difficult to estimate for a variety of reasons (e.g., lack of common definitions, variable screening, inconsistent record keeping) [IASSID Special Interest Group on Parents and Parenting with Intellectual Disabilities, 2008]. Most U.S. and international research on cognitive disabilities and parenting has used low IQ, as opposed to a formal diagnosis of intellectual disabilities, (American Psychiatric Association, 2000) to delineate samples, i.e. parents with IQ's in the Borderline to Mild Mentally Retarded ranges. Although larger scale epidemiological studies are needed, findings suggest that a higher than expected proportion of low IQ parents find themselves in the CPS system, with estimates ranging from 33 to 78%, most involved for neglect (Aunos, Goupil, & Feldman 2003; Ethier, Couture, & Lacharité, 2004; McGaw, Shaw, & Beckley, 2007; Morch, Skår, & Andresgård, 1997; Schillings, Schinke, Bylthe, & Barth, 1982; Tymchuk & Andron, 1990). These rates are much higher than in the general population (10.6 per 1,000 children) [ACYF, 2007]. Although less data is available, parents with low IQs also appear to constitute a larger than expected proportion of CPS cases based on population prevalence of parents in these IQ categories. Indirect data comes from poverty studies.

Poverty has been strongly associated with child maltreatment (Sedlak & Broadhurst, 1996) and studies of Temporary Assistance to Needy Families (TANF) samples suggest that between 25 and 35% have IQs below 79, and as many as 50% have learning disabilities (U.S. General Accounting Office [GAO], 2001). Rates of PCD within CPS caseloads are likely close to this range. Only one study could be identified where a rate for a CPS sample was computed directly and it, unfortunately, was a select sample (cases that had court involvement). This study found a rate of 15% (Taylor, Norman, Murphy, & Jellinek, 1991), almost double the prevalence of adults who fall within these IQ ranges (8.4%) [Wechsler, 1997]. In addition, this study did not report learning disability data, which may involve a much larger group based on the TANF findings.

Routine assessment for cognitive issues is not done by CPS and thus, cognitive disabilities may go undetected by intake workers. If parents are aware of their cognitive difficulties (i.e., have been formally labeled as being mildly mentally retarded, learning disabled, and/or having special needs), they may not identify their designation to CPS investigators because they no longer identify with a label they were given in childhood, want to avoid stigma and/or may not see the relevance of divulging it. Even if self-identification occurs, parents may not be able to articulate the accommodations they may need from service providers.

There also exists a group of parents that will not be aware of their disabilities. Some adults in our society are not appropriately labeled in childhood due to limitations of school assessment resources or parental wishes, and the specificity of their cognitive difficulties may remain unknown to them. Other adults may develop cognitive problems over the life span (i.e., after the age of 18) that impact parenting (e.g., head injuries in veterans and civilians) [Hoge, Goldberg & Castro, 2009; Jager, Weiss, Coben, & Pepe, 2007; MacCready, 2009].

These last groups may be more common among diverse members of our society who are overrepresented in caseloads (Azar & Goff, 2008). They tend to reside in urban settings where school resources for testing may be low and where violence and head injuries may occur at higher rates (U.S. Department of Justice, 2000). Moreover, health care disparities exist for

minorities, which lowers the probability of their difficulties being identified (Collins et al., 2002). For example, head injuries in minorities may not receive as much attention or after care (e.g., Bazarian, Pope, McClung, Cheng, & Flesher, 2003). Thus, subtle, residual cognitive problems may remain unidentified.

Most relevant to our discussion is recent theorizing that has argued that selective cognitive difficulties lead to parenting risk (Azar & Weinzierl, 2005). IQ may merely be capturing a group with a higher density of specific cognitive problems that more closely link to difficulties in parenting (poorer monitoring of children, inconsistent medical care, poorer hygiene, etc.) [See Benjet, Azar, & Kuersten-Hogan, 2003.] However, these difficulties will be present across the full spectrum of IQs. We and others have identified links between social information processing (SIP) difficulties and parenting risk. We also have preliminary data with a small sample showing that low IQ parents exhibit inappropriate expectancies of self-sufficiency from their children (i.e., maladaptive schema), poorer problem solving capacities, and more negative appraisals of their children's behavior (Azar & Robinson, 2008). As with existing categories of cognitive disabilities (formal diagnosis of mental retardation; learning disabilities), these subtler SIP problems are not easily detected by untrained eyes. Service adaptations, we argue, are required to appropriately identify and intervene with all of these (Azar, 1989) before skills work can be done with parents.

In summary, existing data suggest a significant portion of CPS cases have some form of cognitive challenges that may affect their parenting (e.g., planning capacities needed to maintain home cleanliness and to monitor children's safety) and that these cases may go unidentified by the system. These same challenges have functional significance for how well service providers (CPS workers, parent trainers, therapists) work with parents. It is the promotion of cognitive capacities in service providers that is the focus of our discussion. We use SIP theorizing to consider providers' social cognitive system and the potential to make errors and be less effective in service provision when the impact of parental cognitive challenges go unidentified "in the moment." Ultimately, this impacts on providers' own sense of efficacy in their work.

In considering systemic changes, we will focus on the parent with identified challenges, as this is where biases may emerge and adaptations are easily made. Because failures to identify challenges are likely, we will also argue for a “universal design” approach to systems changes.

### Parents with Cognitive Disabilities: A New Frontier of Systems Change

Much progress has been made in the societal treatment of the cognitively disabled over the last century. For example, educational systems have “flexed” their boundaries and developed a whole system of specialized services for children with cognitive disabilities. This system is equipped with well trained staff that have the skills to work with disabilities. Adulthood, however, presents new challenges, and society has not shown the same level of systemic flexibility. In fact, biased views continue to exist, and this bias is particularly apparent when it comes to parenting by adults with cognitive disabilities (Aunos & Feldman, 2002).

In the earliest forms of discrimination toward parenting by individuals with cognitive disabilities, society went so far as to allow their sterilization (Buck v. Bell, 1927; Landman, 1929). Although such treatment has thankfully been abolished, it has been argued that biases continue and discriminative practices occur, although in less blatant forms (Field & Sanchez, 1999; Hayman, 1990; McConnell & Llewellyn, 2000). It has been noted that the pregnancy of an adult with cognitive challenges is not celebrated and, instead, is seen as a cause for concern for those around them, especially professionals (Llewellyn, 1994). Rather than creating a network of supports to enhance parents’ optimal functioning in this role, societal supports may be minimal or non-existent in most communities. In fact, reaction may be more punitive, with some states’ procedures allowing CPS to remove children at birth in the hospital until risk is ruled out.

Even if societal action does not take place at this point, because of their greater need for supports (health issues, social support) and the randomness with which supports are more likely to occur (e.g., the mailman being willing to read the mail

for the parent), PCD may struggle. At the same time, their parenting practices may be scrutinized more closely than parents without such disabilities (Field & Sanchez, 1999). Unless they have supportive families and communities that compensate for their impairments, CPS involvement and removal of children may be more likely.

Additionally, once children are removed, heightened risk of termination of parent rights has been found (Feldman, 1998; Seagull & Scheurer, 1986; Field & Sanchez, 1999; McConnell & Llewellyn, 1998). Differential treatment appears to occur, despite legal mandates such as the American with Disabilities Act (ADA, 1990), which specifically states that such disabilities should “in no way diminish a person’s right to fully participate in all aspects of society” (Title 42, Chapter 126, Sec. 12101), and case law that prohibits categorical a priori assumptions of risk (i.e., diagnoses must be linked to functional incapacities that lead to significant child risk). Despite the influence of the ADA on changes in a number of social welfare areas, including housing, education, vocational services, and public health, there is a notable lack of focus upon the rights of PCD to reasonable accommodations in their parenting services (Bartell v. Lohiser, 1998). We will argue for the kinds of human capacity building that is required for CPS staff and its contracted service agencies to provide accommodations and facilitate linkages to other systems that serve people with intellectual disabilities.

We believe that CPS will be less effective with cases involving PCD because of a mis-match of their typical approaches to what may be the special needs of the parents involved (e.g., a high reliance on parents orchestrating their own services, time-limited parent education as the vehicles for change, and traditional service provision, such as psychotherapy) and residual biases that still exist toward this population. A more refined approach that has more of a rehabilitation focus may be more effective, reduce the number of chronic CPS cases, and improve workers’ efficacy in their jobs.

### Building Capacity

Capacity building is a crucial element of system change and involves activities that (1) strengthen the knowledge,



abilities, and skills of service providers, and (2) provide improvements to institutional structures and processes such that CPS can efficiently meet its mission and goals in a sustainable way. Capacity building is much more than training and includes human resource development and organizational development. *Human resource development* provides fluidity, flexibility and functionality to CPS caseworkers and contracted agency staff and facilitates adaptation to the needs of PCD. This may be accomplished by improving pre-professional training, setting new priorities in hiring standards for staff, continuous enhancement in service delivery, and ongoing supervision/consultation with established personnel. *Organizational development* can include not only changes within the organizational structures (more refined supervision and consultation resources), but also the management of relationships between the organizations and other sectors (public, private and community). We will focus our discussion upon human resource development and touch on organizational development.

The TANF system has begun to make changes to improve its effectiveness and has recently identified disabilities as an area where efforts are required (U.S. General Accounting Office, 2001). Additionally, as noted earlier, the educational system has already made such changes with varying levels of success. CPS can benefit from the efforts in both these systems. Below, we first outline a framework for capacity building, then highlight human resource enhancements and finally, touch upon organizational development that may improve practice using this framework.

### *Social Information Processing as a Foundation for Capacity Building*

Human capacity building requires that progress take place on multiple levels of the service system, ranging from CPS policies and procedures to individual caseworker support and skill-base. This paper will primarily focus on caseworker support and skill as a route to increased effectiveness of parenting interventions provided by CPS. Social information processing (SIP) theory provides a foundation for building the human capacity of CPS workers (Azar, 1996, 2000). SIP models outline the processes whereby the human cognitive system takes in

and utilizes social information. Such models have been used to discuss social cognitive processes that precede problematic and ineffective interpersonal interactions. For instance, the models have been widely applied to parents and risk for child abuse and/or neglect perpetration (Azar, Robinson, Hekimian, & Twentyman, 1984; Milner, 2003) and also extended to attempt to understand professionals working with marginalized populations, such as parents living in poverty (Azar, 1996). These models break down SIP into three core components: (1) biased schemas or knowledge structures (e.g., role schema, expectations of parents, stereotypes); (2) executive functioning capacities (e.g., problem solving, memory, attention); and (3) appraisals or judgments we make about the causes of others' behavior. The first and third elements, schema and appraisals, are most relevant to the facilitation of human capacity building. Although most providers have adequate executive functioning, professionals' flexibility and problem solving capacities may be depleted under stress and it might require extra efforts to remain flexible in thinking and/or to be open to supervisory or consultation input to keep performing effectively (Azar, 2000). PCD may have particular difficulty here, and workers must take this into consideration as they assist them (Azar, Read, & Proctor, 2008).

The first element, schemas, act as the foundation for SIP. Schemas are knowledge structures stored in memory that help people organize past experiences and respond to novel situations (Mandler, 1979). These knowledge structures grow out of interpersonal experiences, including interactions within one's family, exchanges with other individuals, encounters with institutions, exposure to media representations, and even through professional training (e.g., social worker training). The schemas held by professionals regarding people with intellectual disabilities are often tainted with negative elements. Although it might be argued that professional training and knowledge guard against the use of heuristics that stem from one's own personal background, the training of CPS workers in the U.S. includes limited, if any, information about parents with intellectual disabilities (Hughes & Rycus, 1998). Changes in training and supervisory support to facilitate adaptive support schemas will be discussed.

The final element of SIP, appraisals, are causal explanations given to situations that do not meet professionals' expectancies. Inaccurate schema may lead to misappraisals of the causes of parental behavior. For example, when a parent misses appointments consistently, a worker may label them as "resistant" or "not caring" because the parent is not adhering to CPS expectations. However, this label would be different should the worker consider that the parent may be unable to tell time, has planning difficulties, or does not understand bus schedules. Consideration of a PCD's strengths and needs may reduce inaccurate negative appraisals.

The following sections will outline skills designed to increase the human capacity of the dedicated CPS workforce. Throughout this discussion, SIP processes will be highlighted as the underlying mechanisms of a successful supportive relationship between the worker and PCD.

*Working with the Parent with Cognitive Disabilities:  
Human Resource Development*

*Identification skills.* Identifying the presence of cognitive disabilities is a crucial first step to making appropriate adaptations. Two forms can occur: formal screening (with triaging for further testing for verification and identifying capacity issues, e.g., optimal learning style) and "in the moment" identification (with adaptation to address a communication difficulty).

As noted above, the CPS does not currently routinely screen for cognitive challenges. Such screening is beginning to take place in other systems (TANF) [Center on Budget and Policy Priorities & Center for Law and Social Policy, 2007; U.S. General Accounting Office, 2001], and some attempts have been made to develop screening tools for functional deficits relevant to parenting (Connecticut Department of Children and Families, 2008; Whitman & Accardo, 1990), although validation of such instruments is quite limited. Nonetheless, they may provide some starting point for CPS staff. Additionally, formal identification focusing on functional capacities may be more useful (see Tymchuk, 2006 for empirically derived batteries), though such assessment may not be practical at CPS intake and might be better done by staff at provider agencies (with feedback given to ongoing CPS staff to ensure continuity).

Given the status of screening instruments and the sheer number of CPS parents that may have difficulties, a more universal design may be more efficient at present. This approach would require the professional to take care at all times to recognize points of disconnect between their communications and what all parents have grasped. Although we recognize that this may be viewed as just good social work practice, obstacles specific to PCD must be noted. It has been said that the individual with cognitive challenges will adopt a "cloak of competence" (Edgerton, Bollinger, & Herr, 1984) in which they may portray themselves as understanding material when they do not. PCD may also be prone to styles of coping that inhibit their capacity to seek and/or accept expert assistance. Also, parental inability to understand what is being asked of them may result in frustration and avoidance of contact, which may be misappraised by CPS or a service provider. Therefore, the professional has to be extremely sensitive to those moments when assistance is needed (e.g., constantly checking parents' understanding and their behavioral capacities to enact what is being asked of them), and doing it in a way that is not stigmatizing or infantilizing. Skills, therefore, at reducing "disconnects" between parent level of functioning and CPS expectations may need to be a focus of staff development.

*Process strategies.* PCD often do not respond well to traditional didactic parent education (Whitman & Accardo, 1990). They often have difficulties with purely auditory instruction (Bakken, Miltenberger, & Schauss, 1993). Multimodal approaches that include auditory, visual, and kinesthetic strategies, using concrete examples, and in-home work to promote generalization work best (Feldman, 1994; Green & Cruz, 2000). This information should alter the expectations held by CPS workers and the larger system for parent response to intervention as well as provide tools of intervention and interaction.

First, training of CPS workers and staff of contract agencies needs to accommodate different learning styles. Adaptations may need to be made regarding the rate at which material is presented, the time frame in which change is expected, and the duration of and types of supports needed to maintain parenting capacities over time (e.g., a network of doctor's offices that provide more active prompts for child

appointments, the use of visual aids). The ability of a caseworker to correctly identify the range in which a parent can complete a task with appropriate scaffolding, though not independently (i.e., the "zone of proximal development") [Vygotsky, 1978] relies upon appropriate expectations. Realistic expectations of parental capacity may result in an attribution that additional, possibly long-term, support is needed. The disparity between the time-limited focus of many social service interventions and the long-term support needed by many PCD must be directly met in CPS system change, and there are no easy solutions. Discussions of "supported" parenting programs" are taking place nationally (see *Through the Looking Glass*, 2008; North American Coalition for Parents with Intellectual and Cognitive Challenges, 2008) and input may eventually come from these groups.

Second, capacities in functional assessment of parenting behaviors will provide a tool to increase the workers' sensitivity to where the parents' cognitive problems interfere with their mastery of a skill (e.g., being able to identify when the parent's limited ability to take the child's perspective is interfering with an interaction and that this capacity needs addressing first). Functional assessment looks beyond the behavior itself in order to identify the underlying purpose (function) for the behavior (e.g., the reason for what is often labeled as parents' "lack of motivation" to engage with CPS intervention) and how and why the trained behaviors are not being maintained (e.g., limited organizational or planning skills that require assistance). The function of a behavior can be determined via assessment of the antecedents that occur prior to and consequences that occur after the behavior. By focusing on the antecedent conditions, which include characteristics of the parent, such as beliefs, attitudes and level of functioning, the caseworker is better able to understand the behavior of the parent and adjust and elaborate on interventions accordingly. Formally, functional behavioral assessment (FBA) is a multi-method strategy that has been used with adults and children (Gresham, Watson & Skinner, 2001; Hanley, Iwata, & McCord, 2003). However, the principles of FBA are relatively simple, and are a helpful frame for working with adults with cognitive challenges in CPS. Once the maintaining factors are

determined, professionals can work alongside the parents to increase the conditions that support successful parenting and decrease obstacles.

Finally, lists of competencies for professionals working with disabilities have been suggested by various training organizations (see Institute for Human Services, 2008). For example, triage and referral skills are needed. Deep understanding of multiple systems of care (DMR, MH, EI) is also needed, such that consultation and assistance can be sought respectfully and with the right level of specificity of referral information and careful follow-up. Here, too, a SIP framework is helpful as the various professions use different language and approaches and tensions can be identified that have their roots in these differences rather than real differences of opinions. Abilities to provide more than crisis management, such as identification of the need for more long term planning, intervention, and perhaps lifetime supports, are also required.

*Breaking down biases and promoting empowerment.* Biases continue to exist toward the PCD that may interfere with the work that is done by CPS and with the professionals at contracted agencies. Biases can include a belief in parental incompetence and expectations of failure in the role of parenting, and/or a view that parents cannot act as agents on their own behalf and are not amenable to intervention. Efforts to sensitize staff to implicit biases and active skills training in empowerment strategies may both be important to break down barriers to success.

Values assessments (exploration of the nature of one's schema toward the cognitively disabled individual) and staff discussions are crucial to begin to challenge biases toward PCD. Our research group is developing methods using new technology for assessing prejudice attitudes in professionals to facilitate a recognition of their own potential for bias (see the Implicit Association Test (IAT) demonstration by Project Implicit at <https://implicit.harvard.edu/implicit/demo/> and the discussion in Azar & Goff, 2008). Ongoing consultation with professionals whose career focuses on working with cognitive disabilities (DMR staff, special education staff) may be useful and can provide role models for the kinds of slow and methodical work required to affect change. They can also

model the kind of self-challenging of biased schema elements required using strategies used in cognitive behavioral therapy (e.g., cognitive restructuring or problem solving therapy) [Azar, 1996; Beck, 1993]. Evidence-based programs on reducing biased schema regarding other stigmatized groups have been used in other professions and might be adapted for use as a first step (e.g., physicians, mental health staff) [McDowell et al., 2003]. It should be noted, however, that the data regarding these programs' long-term effectiveness are less than satisfying (e.g., effects may deteriorate over time). Continued work in supervision as a follow-up to such programming may assist in maintaining their effects.

Skills with empowering parents to participate in program development are also crucial (see the North Dakota Center for Persons with Disabilities, 2009; Kennedy Krieger Institute's PACT: Growing Together Program, 2009). Individuals with intellectual disabilities have been said to exist within a "culture of dependency" (Whitman & Accardo, 1990), in which they rely upon the support of others to obtain goals that are often determined by others, especially providers and family. Recently, there has been movement towards self-determination and empowerment. Although these interventions have no single definition, they generally focus upon removing the responsibility for the creation and maintenance of goals from external sources and providing at least part of the responsibility to the individual with cognitive disability (Swift & Levin, 1987; Wehmeyer & Mithaug, 2006). These interventions inform the individual of options and choices regarding the form and content of support, facilitate individuals' independent decision-making, and permit the individual to provide input to her or his intervention (Mansell & Beadle-Brown, 2004; Neely-Barnes, Marcenko, & Webber, 2008). This control over one's own treatment has been found to increase the quality of life (e.g., vocational rehabilitation, reported life satisfaction) of adults with chronic mental illness (Rosenfield, 1992). Some efforts to increase empowerment have occurred in the child welfare system, but these are mostly directed toward the extended family of the parent who has perpetrated maltreatment (e.g., Family Group Decision Making Models) and have grown out of an increased use of kinship care (Crampton, 2007).

While empowerment interventions have gained popularity throughout the mental health field, questions remain regarding the feasibility and impact of such interventions. One question is whether PCD experience the interventions as empowering or not. A second question is whether it is feasible to “level” the playing field for PCD, given the differential power relationships that often exist between parents and CPS (e.g., mediation) [Barksy, 1996]. While these questions require further research, supervision designed to constantly challenge the worker’s expectations and appraisals regarding the parent’s agency in decision-making and goals may start a process of shifting away from long held biases in this area (Azar, 2000).

### *Working with the Parent with Cognitive Disabilities:*

#### *Content of Programming*

Programs exist in the U.S. and internationally that provide examples of the human capacity adaptations needed to maximize effectiveness of CPS interventions for PCD (e.g., Feldman & Case, 1999; Feldman, Case, & Sparks, 1992; Green & Cruz, 2000; Heinz & Grant, 2003; Lutzker, Bigelow, Doctor, Gershater, & Greene, 1998; McConnell, Matthews, Llewellyn, Mildon, & Handmarsh, 2008; Tymchuck, 1999, 2006). Remembering that a single, prescriptive formula for meeting the needs of PCD is an oversimplification of the issue (Llewellyn, McConnell, & Bye, 1998), these programs offer a variety of tools for working with the special population. They utilize many of the functional adaptations outlined above, such as multi-modal skill-based intervention, individualized plans and collaborative goal setting and management, while targeting basic parenting skills relevant to this population (e.g., basic child care such as safety, hygiene, and medical care) [Feldman & Case, 1999; Tymchuck, 2006].

Although the explicit adaptations made to the interventions in content and processes of implementation, implicit in these programs are developmentally sensitive expectations of the parents’ style and speed of acquisition of information (i.e., adaptations to schema). These realistic expectations likely decrease negative attributions that would increase caseworker withdrawal and feelings of helplessness (e.g., attributions of parental incapability, laziness and/or lack of motivation) and



increase attributions that will increase caseworker motivation and self-efficacy (e.g., attributions of parental need for specialized, adapted support) [see Azar, 1989 for how this is done explicitly in the context of purely behavioral approaches]. Evidence-based adapted approaches that target both behavioral and SIP elements, such as those cited above, should be incorporated into CPS practice in ways that allow PCD an active role in determining their treatment goals. For instance, PCD report wanting more services addressing vocational needs and assertiveness skills and report being “over-serviced” in the child care area (Walton-Allen & Feldman, 1991) that CPS prioritizes. Adapted interventions exist in these domains that could be integrated into parenting programs for PCC (see Greenspan, Shoultz, & Weir, 1981).

*Beyond the Parent: Establishing Better Social Support Networks*

Along with evidence-based contracted work, attention needs to be given to building formal and informal networks of support for individual cases. This is essential to break up the social isolation that is common among PCD. Individuals with cognitive challenges are less likely than individuals without these challenges to live with a partner or have close friends or neighbors (Hassiotis et al., 2008; Llewellyn & McConnell, 2002). Increasing social networks with other parents (ones with and without disabilities) will help reduce social isolation, build parent empowerment, and help with the sharing of resources and information (Tarleton & Ward, 2007).

In addition, programs have emerged that utilize community mentors and lay advisors for PCD. Community mentors and lay advisors can accompany parents to appointments, help “translate” legal and medical information, help scaffold problem solving in parenting situations, and help access resources. Programs that combine community mentors who can help parents navigate in the community and residential placements for entire at-risk families have shown effectiveness in increasing self sufficiency and family preservation (Barth & Price, 1999). Efforts to operationalize this have occurred (Arc of Franklin & Hampshire Counties, 2007; Legal Services Law Line of Vermont, 2008) and could be incorporated into CPS interventions.

However, external sources (i.e., caseworkers) cannot be the sole creators and maintainers of social support networks. Instead, PCD must be provided with effective training on skills to increase the probability of continuity in their social support network. Such skills include assertiveness training, skill-based workshops offered in an individual or group setting. In fact, social skills training with a focus upon modeling and/or in vivo practice and feedback has been found to be effective with adults with intellectual disabilities (Bidwell & Rehfeldt, 2004).

### *Organizational Support Networks across Public and Private Systems*

PCD interact with multiple service systems (e.g., housing, welfare, schools, and courts) [U.S. GAO, 2001], which can cause confusion and fear on the part of the parent. Integration of these multiple services is needed. In fact, fewer service providers along with faster service implementation has been linked to satisfaction with CPS generally (Chapman, Gibbons, Barth, McCrae, & NSCAW Research Group, 2003) and may be more crucial for PCD. The CPS system should focus attention on building ongoing networks of support within existing systems for the benefit of both PCD and CPS workers. Networks of professionals in the local community that have expertise relevant to cognitive challenges are necessary. An example would be medical professionals who can provide more appointment reminders, translate medical jargon, and patiently provide information on medical problems and how to handle emergencies to scaffold parents' effective utilization of child health care (Heinz & Grant, 2003).

In addition, CPS workers can feel isolated and overwhelmed due to the multiple needs of parents with PCD. Other systems have staff with more training in working with cognitive challenges (Department of Mental Retardation) and linkages with these systems may enhance services CPS can provide. Informal associations (such as consultation, staff sharing) may be possible through cooperative agreements. CPS workers would also benefit from partnerships between CPS and community agencies for adults with cognitive challenges (e.g. ARC), as they would help integrate efforts and resources, reduce the burden for individual caseworkers, and facilitate relationships

between PCD, the community and other individuals. Some evidence exists that this occurs in some locales (Arc of Franklin & Hampshire Counties, 2007) or at the case level, but it is unclear how widespread or systematic this collaboration is. Ultimately, these extended supports could reduce recidivism by increasing connections that can serve as resources in times of crisis and reduce barriers related to PCD biases (Tymchuk, 1999).

## Conclusions

In this paper, we have built an argument for PCD as comprising a significant proportion of CPS caseloads. Cognitive disabilities, as reflected in SIP deficits, affect parents' capacity to interact with CPS workers in many cases and require accommodated services in order to provide effective parenting support. Though other systems have made efforts to include individuals with disabilities, CPS has been less touched by the mandates of ADA. We call for similar, pervasive system change with human capacity development and organizational linkages to provide support for the CPS system and the PCD within the system. Although our focus has been on parents with a formal diagnosis, we argue for the benefit of a more universal approach so that unidentified, "silently" disabled parents may benefit as well.

We believe with increased CPS worker skills and knowledge, moment-by-moment interactions with PCD (both those with formally identified disabilities and those who may have unidentified difficulties) will be less fraught with difficulties. With accommodated programmatic changes in the content and process of interventions, effectiveness will increase. These adaptations would both remedy broader concerns regarding worker burnout and allow parents to retain custody of their children and more easily enact this important parenting role.

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