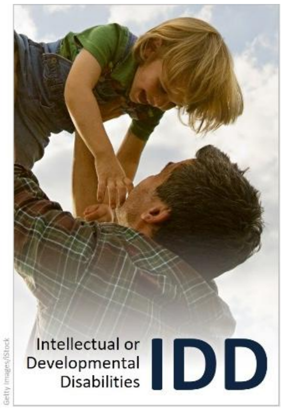

A Descriptive Profile of Parents with Intellectual or Developmental Disabilities and Their Children

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ACCORDING TO THE AMERICAN COMMUNITY SURVEY 1-year estimates for 2022, 1,037,142 individuals with disabilities reside in Washington State, representing 13.5 percent of the state's population (U.S. Census Bureau, 2023), while 435,323 individuals experience cognitive difficulties. Individuals with intellectual or developmental disabilities (IDD) are a subset of the overall population of individuals with disabilities. In 2023, the Department of Social and Health Services (DSHS) Home and Community Living Administration, Developmental Disabilities Community Services (DDCS) carried a caseload of 54,533 individuals who were determined eligible for DDCS services.[1] While DDCS reports basic demographic information about their caseload annually, little is known about the needs and challenges faced by parents who have IDD in Washington State and their children (Collings and Llewellyn 2012). This report presents a descriptive portrait of parents who have IDD, their needs and access to services, as well as the characteristics and potential service needs of their children.

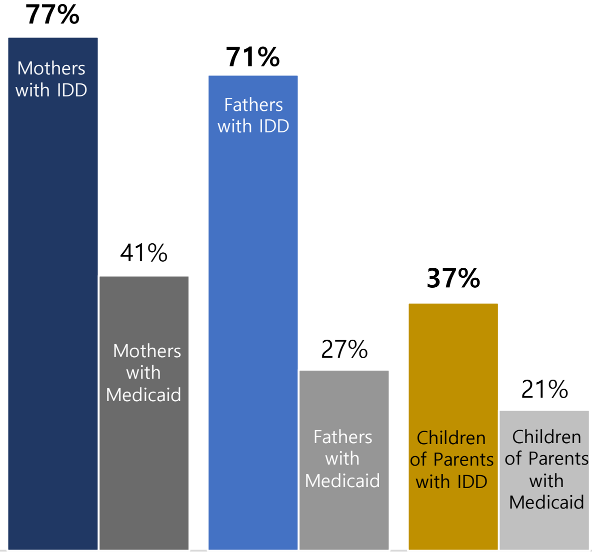
Key Findings

1. **Parents with IDD have higher rates of health conditions compared to Medicaid clients who are parents.** For instance, 77 percent of mothers and 71 percent of fathers with IDD had a mental health diagnosis. These percentages were higher than those for mothers (41 percent) and fathers (27 percent) who are Medicaid clients.
2. **Parents with IDD have increased involvement with child protective services (CPS) and higher utilization of economic services compared to parents enrolled in Medicaid.** Their use of Basic Food assistance is high (71 percent for mothers and 67 percent for fathers), about 20 percentage points higher than that of Medicaid parents. Parents with IDD also have lower employment rates compared to parents enrolled in Medicaid.

FIGURE 1.

Mental Health Treatment Need

Among Parents and Their Children



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[1] RCW 71A.10.020: Definitions

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3. **Within the population of parents who have IDD, mothers experience more adverse health conditions and have higher service utilization as compared to fathers with IDD.** For instance, mothers have higher medical risk, mental health treatment need, and emergency department use. Receipt of Temporary Assistance to Needy Families (TANF) and Basic Food Assistance was also higher among mothers with IDD as compared to fathers with IDD. These differences were also true when comparing mothers and fathers enrolled in Medicaid.

4. **Children of parents who have IDD have more health conditions, and higher social and health service utilization compared to the broader population of children of parents who are Medicaid clients**. In addition to having higher rates of health conditions relative to children with a parent enrolled in Medicaid, children of parents who have IDD have increased rates of well-child visits, emergency department visits, and involvement with the child welfare system (including out-of-home placement). They also have increased utilization of economic assistance such as Basic Food and TANF.

Study Design

The study population includes parents who have IDD and their children. The comparison group includes Medicaid clients who are parents and their children. Parents and their children are identified using birth certificate data from 2006–2023.[2] Medicaid clients with non-Medicaid primary health care coverage, also referred to as third-party liability (TPL), and those who were dually eligible for Medicaid and Medicare ("Duals") are included. For measures involving medical conditions and health service utilization, numbers and percentages are shown for those with "Medicaid only", a population subset that excludes Duals because complete health care information may not be available for these individuals.

To examine service use and client characteristics for the study populations, we focused on State Fiscal Year (SFY) 2023. We used the DSHS Integrated Client Databases (ICDB) to generate descriptive indicators of demographics, health and behavioral health conditions, health services, medical coverage, child welfare measures, economic services, employment, and child care services all measured in SFY 2023. See the Technical Notes for complete descriptions of all measures.

Focal populations include:

Parents with IDD and Their Children: (mothers, n = 1,023; fathers, n = 523; children of parents with an IDD, n = 2,524): Parents with IDD include (1) DDCS clients or (2) Medicaid-enrolled clients who have diagnoses of Intellectual Disability, Autism Spectrum Disorder, or other developmental conditions in their ProviderOne Medicaid claims *who were also* listed as a parent on a birth certificate. Parents with IDD were restricted to individuals ages 13–64 years who, according to Washington State birth certificates, had children ages 0–17 years. The same birth certificates were used to identify the children associated with those parents with IDD. Children of parents with IDD had at least one parent with IDD.

Parents Enrolled in Medicaid and Their Children (mothers, n = 234,147; fathers, n = 127,791; children n = 494,830): Parents in this group include Medicaid clients[3] identified as parents using birth certificate data. Parents enrolled in Medicaid were restricted to individuals ages 13–64 years, with children, ages 0–17 years. The same birth certificates were used to identify the children associated with parents enrolled in Medicaid. This population is not mutually exclusive of the population of parents with IDD and their children.

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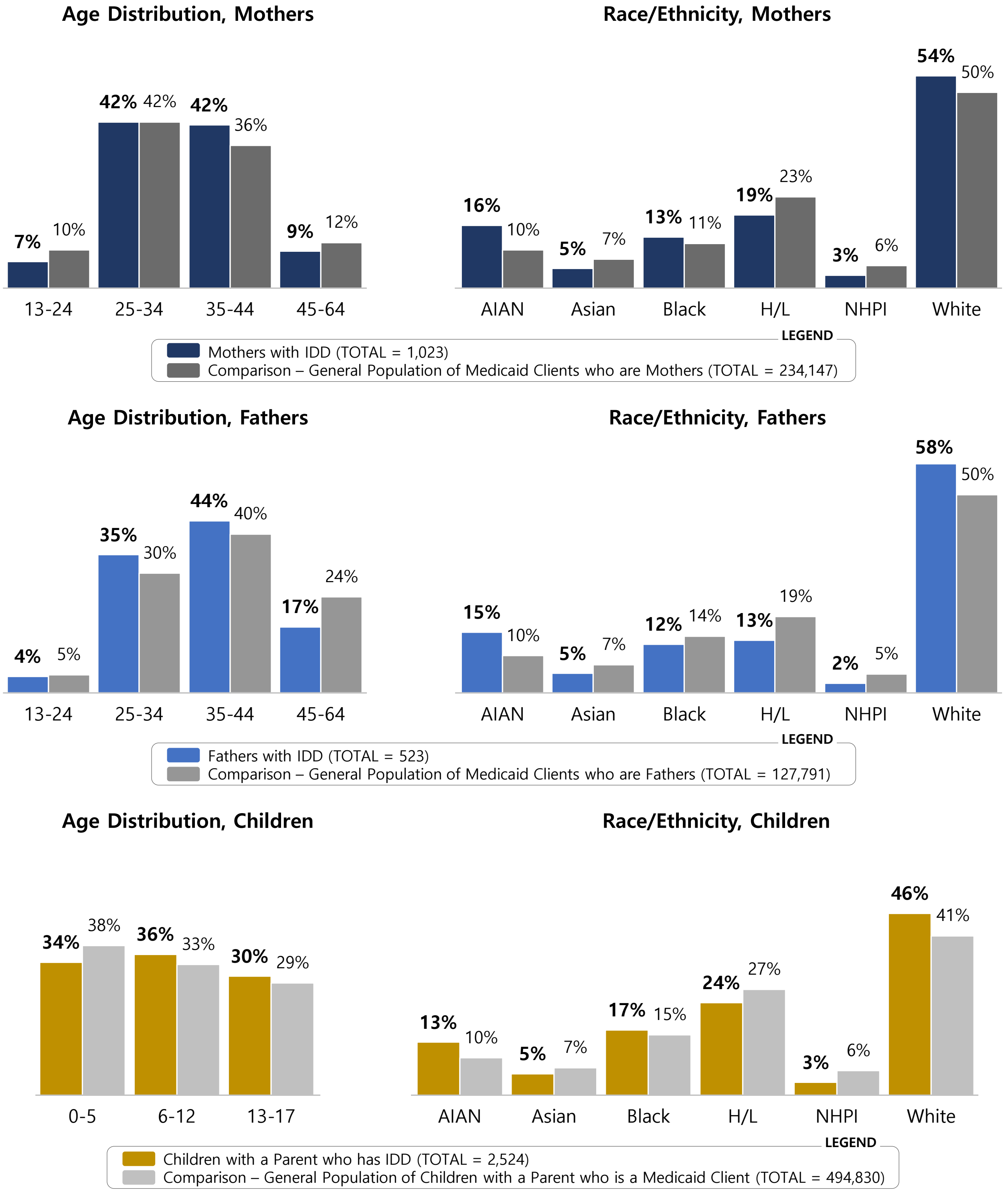
[2] As of 2014, records do not include out-of-state deliveries to Washington State residents because birth certificates for states other than Washington are not available for record linkage.

[3] Includes individuals enrolled in Medicaid or related publicly funded health coverage.

Client Demographics

FIGURE 2.

Demographics



AIAN = American Indian/Alaska Native • **Black** = Includes African American • **H/L** = Hispanic or Latino
NHPI = Native Hawaiian or Pacific Islander • **White** = White, Non-Hispanic

We examined demographic characteristics among mothers and fathers with IDD and their children, as well as Medicaid clients who are parents and their children (Figure 2, above). Most of the mothers with IDD were 25–44 years of age (84 percent), as were most fathers with IDD (79 percent). This trend was similar for Medicaid clients who are parents. Children of parents with IDD were distributed with about one-third in each age group (34 percent 0–5, 36 percent 6–12, and 30 percent 13–17).

More than half of the mothers (54 percent) and fathers (58 percent) identified with IDD were non-Hispanic White while only about half of Medicaid client mothers and fathers were non-Hispanic White. There were also higher percentages of American Indian and Alaska Native (AIAN) mothers and fathers with IDD compared to AIAN mothers and fathers who are Medicaid clients, as well as higher percentages of black mothers with IDD compared to black mothers who are Medicaid clients. Children of parents with IDD were more likely than Medicaid comparison children to be non-Hispanic White (46 percent), AIAN (13 percent), and Black (17 percent).

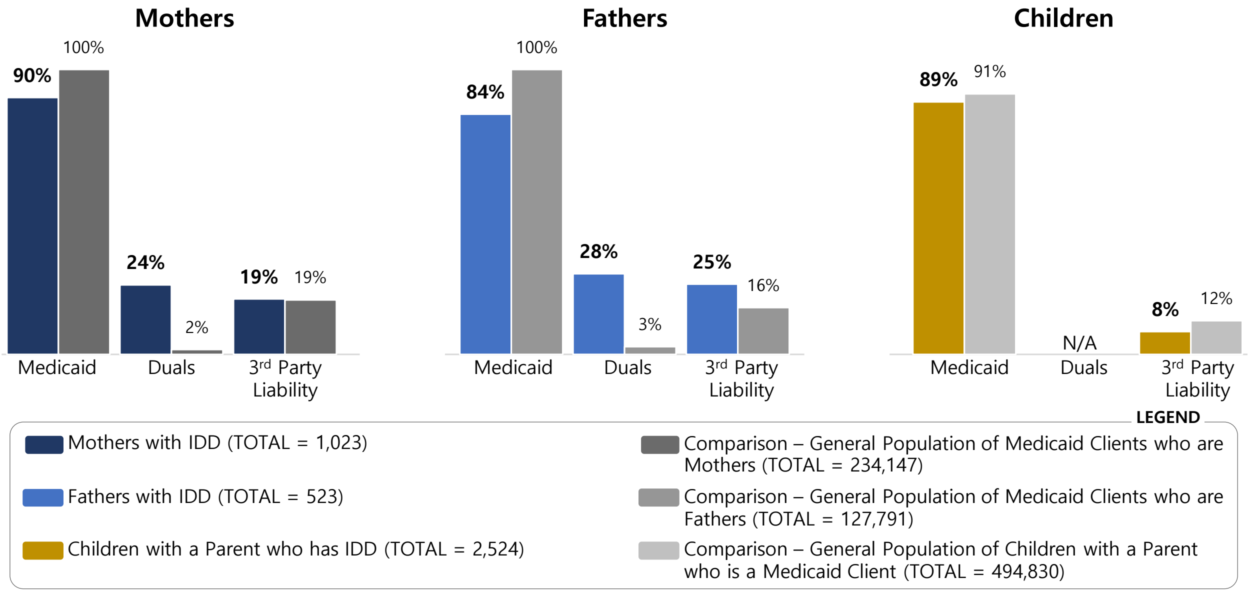
Medical Coverage

Medicaid coverage in CY 2023 was high for both mothers (90 percent) and fathers (84 percent) with IDD (Figure 3). Dual coverage (Medicare and Medicaid) was higher among mothers with IDD (24 percent) and fathers with IDD (28 percent) as compared to mothers and fathers with Medicaid (2 percent and 3 percent, respectively). Nineteen percent of mothers and 25 percent of fathers with IDD had third party liability (TPL) coverage, as compared to 19 percent for mothers enrolled in Medicaid and 16 percent for fathers enrolled in Medicaid.

Medicaid and TPL coverage were lower among children with a parent who has IDD (89 and 8 percent, respectively) as compared to children with a parent who is a Medicaid client (91 and 12 percent, respectively).

FIGURE 3.

Medical Coverage in CY 2023



Medical Conditions and Health Service Utilization

All medical conditions are measured in SFY 2023, and results are limited to clients who were enrolled in Medicaid at least one month during SFY 2023 who are not dually enrolled in Medicare. This is because Medicare claims were not available for this analysis, and those with conditions diagnosed in Medicare claims would be missing from our results. Results are shown in Figure 4.

Obesity. Thirty-one percent of mothers and 19 percent of fathers with IDD were diagnosed with obesity. This percentage was roughly double that of Medicaid clients who are mothers (16 percent) and fathers (8 percent). Children of parents with IDD were also slightly more likely to have an obesity diagnosis than children of Medicaid clients (8 percent versus 5 percent, respectively).

Medical Risk. Medical risk is assessed using the Chronic Illness and Disability Payment System (CDPS) which uses diagnosis and prescription information contained in medical claims to assess disease burden. Forty-nine percent of mothers and 32 percent of fathers with IDD had high medical risk according to CDPS. These proportions were much higher than Medicaid clients who are mothers (22 percent) or fathers (16 percent). Children of parents with IDD had twice the rate of high medical risk (10 percent) compared to children of parents with Medicaid (5 percent).

Mental Health Treatment Need. Seventy-seven percent of mothers and 71 percent of fathers with IDD had a mental health diagnosis. These percentages were higher than those for mothers (41 percent) and fathers (27 percent) who are Medicaid clients. Thirty-seven percent of children with a parent who has IDD had a mental health diagnosis. This percentage was higher than for children with a parent who is a Medicaid client (21 percent).

Substance Use. Twenty-one percent of mothers and 27 percent of fathers with IDD had indications of substance use. This use was higher in comparison to substance use among Medicaid clients; 12 percent of mothers and 18 percent of fathers had indications of substance use.

Any Injury. Roughly the same percentage of mothers (34 percent) and fathers (33 percent) with IDD received treatment for an injury. These percentages were much higher when compared to mothers and fathers who are Medicaid clients (18 and 20 percent, respectively). Injury prevalence was also somewhat higher among children with a parent who has IDD (22 percent) as compared to children with a parent who is a Medicaid client (18 percent).

Emergency Department Utilization. Emergency department (ED) visits, especially outpatient ED visits, were much higher among mothers (51 percent) and fathers (42 percent) with IDD as compared to mothers and fathers who are enrolled in Medicaid (32 and 26 percent, respectively). This was also the case for children with a parent who has IDD versus children with a parent who is a Medicaid client (29 and 24 percent, respectively).

Dental Services. Mothers and fathers with IDD were more likely to receive dental services (38 percent of mothers and 27 percent of fathers) than mothers and fathers enrolled in Medicaid (28 percent of mothers and 21 percent of fathers). For parents with IDD or enrolled in Medicaid, access to dental services was low. Rates of dental services were higher for children of parents with IDD (63 percent) and for children with parents in Medicaid (60 percent).

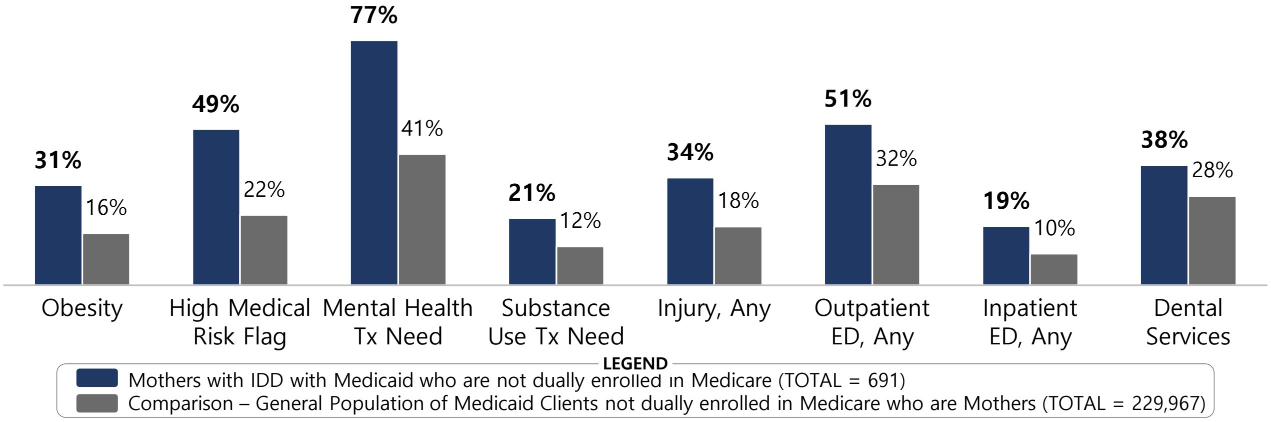
Well-Child Visits. Well-child visits are a positive indicator of health for children as they are an opportunity for primary health providers to evaluate the general health of the child and enable providers to identify and address problems early and help keep children up-to-date on important vaccinations. It is also an opportunity to check in with the parent attending the visit about any concerns they might have. This indicator was higher among children who have a parent with IDD (59 percent) as compared to children with a parent who is a Medicaid client (52 percent).

FIGURE 4.

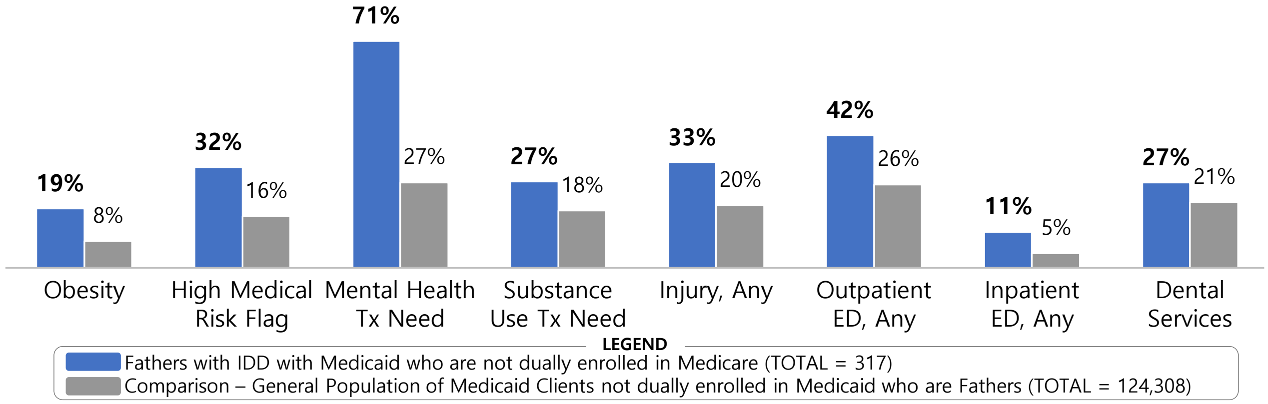
Medical and Behavioral Health in CY 2023

Among Those with Medicaid Not Dually Enrolled in Medicare

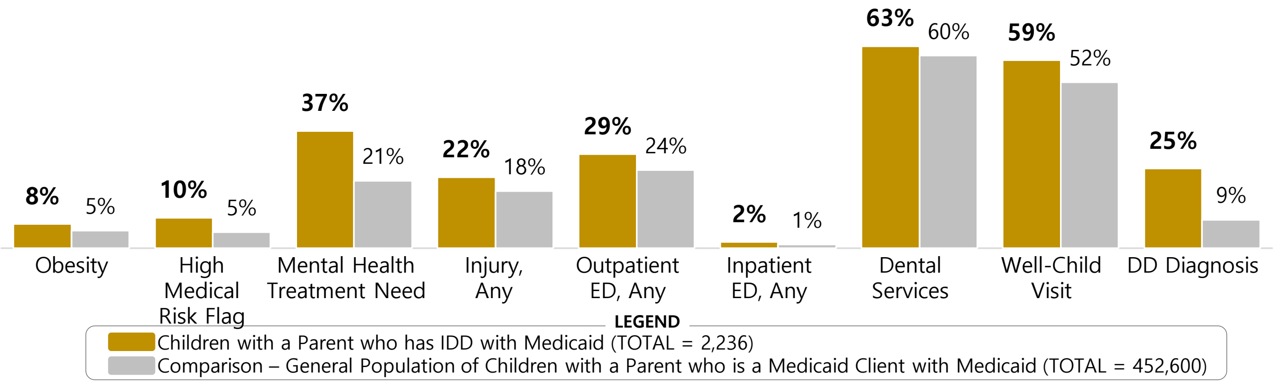
Medical and Behavioral Health Indicators, Mothers



Medical and Behavioral Health Indicators, Fathers



Medical and Behavioral Health Indicators, Children



ED = Emergency Department

Developmental Conditions of Children. Twenty-five percent of children who have a parent with IDD also had a diagnosed developmental condition, which included intellectual disability, autism spectrum disorders, motor or tic disorders, language or learning disabilities, and congenital or chromosomal conditions affecting development. This percentage was much lower for children with a parent who is a Medicaid client (9 percent).

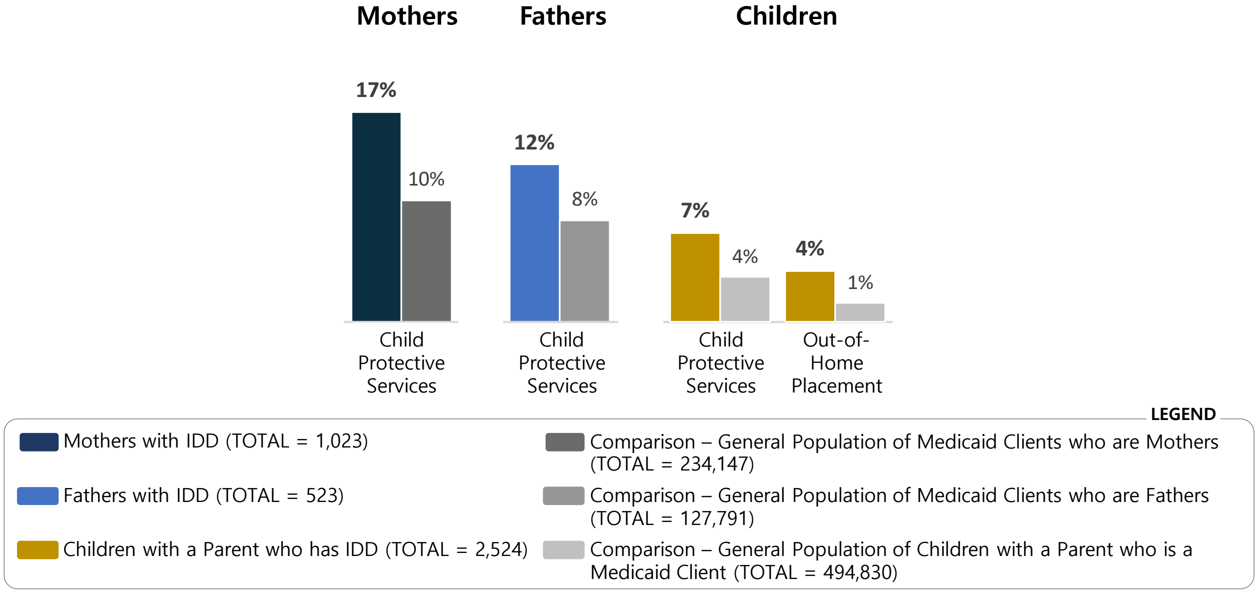
Child Welfare Measures

Child welfare indicators were measured in CY 2023. For child protective services (CPS), we identified if the parent was the subject on an accepted CPS referral and for children we identified if they were listed as a victim on an accepted CPS referral. We also examined whether children were placed out-of-home at any point in CY 2023.

Child Protective Services. Seventeen percent of mothers and 12 percent of fathers with IDD were the subject of a screened-in referral to CPS. Reports were higher than for parents enrolled in Medicaid (10 percent for mothers and 8 percent for fathers). Seven percent of children with a parent who has IDD had an accepted report to CPS, as compared to 4 percent of children with a parent who is a Medicaid client (Figure 5).

Out-of-Home Placement. Children with a parent who has IDD experienced higher rates of out-of-home placement (4 percent) compared to children with a parent who is a Medicaid client (1 percent).

FIGURE 5.
Child Welfare Measures in CY 2023



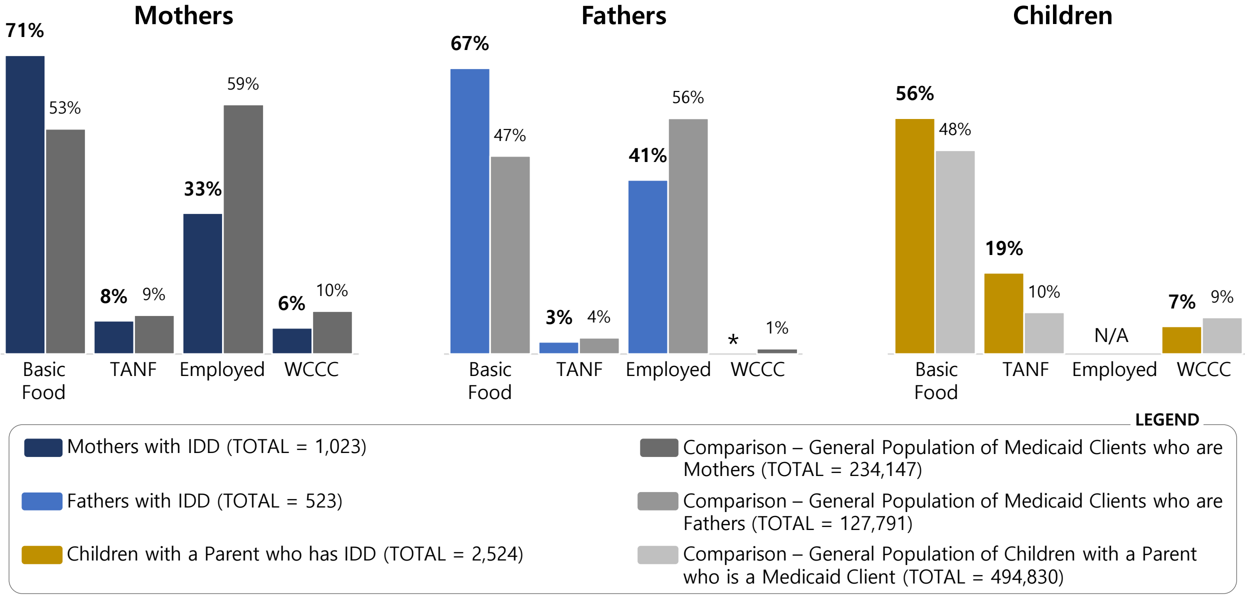
Economic Measures and Childcare Assistance

Basic Food Assistance. Basic Food is Washington State's Supplemental Nutrition Assistance Program (SNAP) and Food Assistance Program for legal immigrants (FAP). A high percentage of mothers (71 percent) and fathers (67 percent) with IDD were recipients of Basic Food assistance (Figure 6). These percentages were about 20 percentage points higher than those for mothers and fathers who are Medicaid clients (53 and 47 percent, respectively). A similar trend was present for children though the percentage point difference was slightly smaller. Fifty-six percent of children with a parent who has IDD received Basic Food versus 48 percent of children with a parent who is a Medicaid client.

Temporary Assistance for Needy Families. Temporary Assistance for Needy Families (TANF) is a cash assistance program for low-income families with children. Only 8 percent of mothers and 3 percent of fathers with IDD received TANF, which was very similar to the levels for Medicaid parents; nine percent of mothers and 4 percent of fathers who are Medicaid clients received TANF. Individuals with a disability receiving Supplemental Security Income (SSI) payments are not able to receive a TANF payment; however, their minor children are still eligible for a TANF grant as long the household meets financial eligibility.[4] This may explain higher rates of TANF among children who have parents with IDD (19 percent) than among parents with IDD themselves.

FIGURE 6.

Economic Measures and Childcare Assistance in CY 2023



*Data suppressed to protect confidentiality (fewer than 11 observations available).

Employment. To estimate employment, we used wage data from the Employment Security Department (ESD). A lower percentage of parents with IDD were employed as compared to parents who are Medicaid clients. The difference was much larger among mothers; 33 percent of mothers with IDD were employed compared to 59 percent of Medicaid client mothers. These corresponding numbers for fathers with IDD versus Medicaid client fathers were 41 percent and 56 percent, respectively.

Working Connections Childcare. Working Connections Childcare (WCCC) is a state childcare subsidy for eligible families allowing parents to participate in a range of approved activities including employment or education.[5] Fewer than 11 fathers with IDD received WCCC; 1 percent of fathers with Medicaid received WCCC. Six percent of mothers with IDD participated in WCCC compared to 10 percent of mothers with Medicaid. Finally, 7 percent of children of parents with IDD participated in WCCC compared to 9 percent of children of parents on Medicaid. Lower participation in WCCC across all three groups could be due to lower employment rates of parents with IDD compared to parents who are Medicaid clients.

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[4] https://www.dshs.wa.gov/sites/default/files/ESA/briefing-manual/2023TANF_WorkFirst.pdf

[5] For more information, see https://www.dcyf.wa.gov/services/earlylearning-childcare/getting-help/wccc

Discussion

This study examined characteristics of and service utilization by parents with IDD, as well as their children. Measurement comparisons were made to Medicaid clients who were parents and their children.

Parents with IDD and their children tend to have more health conditions and risks, as well as a higher utilization of social and health services, when compared to parents on Medicaid. This pattern holds true for such measures as having a behavioral health condition, utilization of the ED for outpatient treatment, well-child visit encounters, reports to CPS, and receipt of Basic Food. One notable exception to this pattern is that children of parents with IDD are less likely to receive Working Connections Child Care. However, this may be related to lower rates of employment among parents with IDD. Taken together, these findings are consistent with previous research (Lineberry et al., 2023; Gómez et al., 2021; Ricciardi, 2013; Lauer et al., 2019; Lunsky and Balogh, 2010).

Additionally, we find that mothers experience more adverse health conditions as compared to fathers. Previous research finds that mothers experience worse mental health outcomes when they have a disability, as compared to fathers (Dunn et al., 2019). Gendered theories of parenting suggest that mothers are more likely to experience parenting stress as compared to fathers as they are more involved in childcare. In a study comparing health outcomes among parents with disability to those without a disability, a higher percentage of mothers with disability had poor or fair health as compared to fathers with a disability (Namkung et al. 2019). Our findings support the results of such research and suggest that gendered aspects of parenting should be considered when designing strategies to support all parents with IDD.

Given the range of potential barriers that a higher percentage parents with IDD face compared to parents in the general Medicaid population, supports in wide ranging areas could be useful. For example, parents with IDD have lower employment rates and lower hourly wages compared to those of Medicaid parents. Expanding employment supports for parents with IDD may be an avenue to explore for improving well-being of the community of parents with IDD and their children. Employment not only provides income but is also key to living a meaningful life and feeling included in a community. There is evidence that both objective and subjective quality of life indicators are increased among people with IDD who are employed compared to those who are unemployed, particularly in competitive employment settings (Randall, 2023).

Health care coordination would also likely benefit this population, since compared to parents in the Medicaid population, relatively higher proportions of parents with IDD have co-occurring health conditions such as mental health, substance use, obesity, and/or other conditions associated with high medical risk. Additionally, higher proportions of their children have health conditions, including chronic health conditions, than children of parents who are Medicaid clients. Parents with IDD and their children are also more likely to visit the emergency department, which may be reflective of their higher rates of medical risk, or difficulties in connecting with a primary health care provider.

It has been established in the literature that parents with disabilities are at increased risk of being involved with the child welfare system, and recent analyses have evaluated compounding factors such as different types of disabilities, poverty, race, as well as the effects of different types of analyses on statistical outcomes, and noted the complexity of the issue (LaLiberte, 2024). In this analysis we find that parents with IDD have higher rates of risk factors for involvement in child welfare, such as indications of poverty and behavioral health conditions, which could partially explain higher child welfare involvement rates. At the same time, it is important to point out that parents with disabilities, by virtue of their higher rates of engagement in the social and health services system, are more likely to experience the surveillance within these systems. This is referred to as "surveillance bias" and could also partially explain higher rates of CPS reports. Further, the child welfare system itself may have negative biases about parents with IDD and their parenting abilities (Albert & Powell, 2020).

Study Limitations

This report is limited to indicators available in the ICDB which are gathered from administrative data collected during client engagement with state social and health services programs. These data systems do not include measures such as educational outcomes or supports, both for parents and children. They also do not have information on stigma, social exclusion, and bullying, which could potentially be experienced by parents with IDD and their children (Collings and Llewellyn, 2012). Our study population of parents with IDD was also limited to those who were either clients of DDCS or Medicaid clients with an IDD diagnosis; parents with IDD who have private insurance and are not clients of DDCS would not be included in this analysis because their data are not available in the ICDB. Therefore, the counts presented in this analysis do not reflect the total number of parents with IDD in Washington State.

Additionally, using birth certificate data to identify parents has limitations. First, some birth certificates do not list fathers, so we are missing a proportion of fathers with IDD and fathers with Medicaid. Also, while birth certificates identify birth parents, they may not reflect parenting relationships accurately. Some individuals may parent children who are not biologically related to them, while other birth parents may not be in a parental role for their biological children. Linkage between datasets using available identifiers can also result in linking errors or missing links. In the case of birth certificates, only name and date of birth were available for linking which limits linkage quality. The limitations related to birth certificates apply to both the parents with IDD and to the broader comparison group of parents with Medicaid, and extend to the identification of the associated children.

Directions for Future Research

Future studies could be undertaken to better understand and address the needs of parents with IDD and their children and their ability to access services. Future studies could examine whether there are regional differences, including geographic differences in access to services among parents with IDD and their children to better understand where additional services should be deployed. It also could be helpful to examine whether access to services varies by race/ethnicity and whether any gaps in opportunities to access services could be reduced. There is little information available about the subpopulation of individuals with IDD who are parents, so additional data could be very helpful to DDCS in planning and designing supports. DDCS could also consider conducting learning sessions with parents with IDD to hear directly from them what supports they may need.

TECHNICAL NOTES

ACRONYMS

CPS	Child Protective Services
DDCS	Developmental Disabilities Administration
DCYF	Department of Children Youth and Families
PMCA	Pediatric Medical Complexity Algorithm
TANF	Temporary Assistance for Needy Families
WCCC	Working Connections Child Care
ED	Emergency Department

DATA SOURCES

Information on client demographics, Medicaid eligibility, risk scores, emergency department utilization, economic services, and behavioral health medical history comes from the DSHS Integrated Client Databases (Mancuso and Huber, 2021) which integrate administrative data from multiple Washington State government agencies. Birth data come from the Department of Health.

Due to Health Care Authority policy, numbers less than 11 and any other numbers that could be used to derive small numbers are suppressed.

MEASUREMENT PERIOD

All measures are constructed using a 12-month timeframe from July 1, 2022, to June 30, 2023 (State Fiscal Year 2023). Birth certificate data are from 2006–2023. As of 2014, records do not include out-of-state deliveries to Washington State residents because birth certificates for states other than Washington are not available for record linkage.

POPULATION

1. DDCS clients (receiving or eligible for DDCS services) in SFY 2023 and/or Medicaid-enrolled clients who have diagnoses of intellectual disability, autism spectrum disorder, or chromosomal or congenital developmental disabilities in their ProviderOne Medicaid claims from SFY 2023 and identified as parents using birth certificate data. The decision to include the three categories of intellectual and developmental disabilities mentioned above was made after discussions with DDCS. Acquired cognitive disabilities such as those from traumatic brain injuries were not included in the definition of IDD. Parents, ages 13–64 years, with children, ages 0–17 years, were selected.

2. Medicaid clients who are parents and their children were identified using birth certificate data. Parents, ages 13–64 years, with children, ages 0–17 years, were selected.

MEASURE DEFINITIONS

1. **Nutritional Deficiencies** were measured using the group of ICD-10 diagnosis codes classified as Nutritional Deficiencies (END007) by Clinical Classifications Software Refined (CCSR) for ICD-10-CM Diagnoses by the Agency for Healthcare Research and Quality (AHRQ), version 2022. See https://hcup-us.ahrq.gov/toolssoftware/ccsr/ccs_refined.jsp for additional information. For example, obesity is measured using the group of ICD-10 diagnosis codes classified as Obesity (END009) by CCSR, version 2022.

2. **Well-Child Visit** indicates a well-child visit in the specified year. Well-child checkups are regular visits with the child's health care provider.

3. **Basic Food** indicates receipt of Basic Food benefit from the DSHS Economic Services Administration. The Basic Food Program provides benefits to individuals and families with incomes up to 200 percent of the federal poverty level (FPL) and whose resources are below established limits. (Prior to October 1, 2008, the income limit was 130 percent FPL.) The program is comprised of the federal Supplemental Nutrition Assistance Program (SNAP) and the state Food Assistance Program for legal immigrants ineligible for federal SNAP benefits. Benefits can only be used to purchase food items at participating stores. This report includes federal dollars that are reimbursed directly to food stores and are not a part of the DSHS budget.

4. **Temporary Assistance to Needy Families (TANF)** indicates receipt of Washington's cash assistance program for very low-income families with children. TANF is a federally funded program that provides monthly cash grants to needy families, children under age 18 (or under age 19 if attending high school or working towards a GED full-time), parents or caretaker relatives of these children, unmarried teen parents under 18, and pregnant women.

Eligibility requires non-exempt recipients to participate in WorkFirst employment and training activities. State Family Assistance (SFA) is a state funded cash program for certain persons meeting state residency requirements who are not eligible for TANF assistance. Those receiving Additional Requirements for Emergent Needs (AREN) grants are included.

5. **Working Connections Child Care (WCCC)** indicates receipt of WCCC that is provided to eligible TANF adults who require child care to participate in approved WorkFirst activities, job searches, employment, or training; and to non-TANF families who require child care to maintain employment or to attend approved training. Clients must pass an economic means test. Client counts in this report include the child receiving service and an adult parent or primary caregiver. Although WCCC as a program is administered by the Department of Early Learning (DEL), ESA determines WCCC eligibility and authorizes subsidy payments for these services. Seasonal Child Care for seasonal employment is included in this report.
6. **Medicaid Coverage** includes all clients receiving any form of Medicaid or other medical assistance for at least one month in the measurement year.
7. **Dual Coverage** flags cases that are dual eligible for Medicaid/Medicare in the measurement year.
8. **Any Diagnosis of a Mental Health Condition** includes individuals with any mental health diagnosis in SFY 2023. The following diagnostic categories are included: psychotic, mania/bipolar, depression, suicide/self-harm, anxiety, attention deficit, impulse control/conduct, trauma/stressor, somatoform, factitious, selected personality disorders, eating disorder, and miscellaneous mental health.
9. **Substance Use** indicates the likely presence of a substance use disorder and was identified from diagnosis and treatment records, or substance-related arrests.
10. **The Medical Risk Flag** represents an individual with predicted future medical costs greater than the average Medicaid participant in Washington state meeting Supplemental Security Income disability criteria. Medical risk scores were calculated from health service diagnoses and pharmacy claim information, with scoring weights based on a predictive model associating health conditions with future medical costs, the Chronic Illness and Disability Payment System (CDPS), http://cdps.ucsd.edu. A risk score equal to one is the score for the average Medicaid participant in Washington State meeting Supplemental Security Income disability criteria. When an individual has a risk score of greater than one, the individual is considered to have high medical risk.
11. **Injury treatment** for an individual is measured as an encounter for treatment in which any type of injury is diagnosed.
12. **Outpatient Emergency Department Utilization.** A claim is identified as an outpatient emergency department visit if it was an institutional (hospital) claim, the claim type was outpatient, and the revenue code or procedure code indicated the visit was to an emergency department.
13. **Inpatient Emergency Department Utilization.** A claim is identified as an inpatient emergency department visit if it was an institutional (hospital) claim, the claim type was inpatient, and the revenue code or procedure code indicated the visit was to an emergency department.
14. **Child Protective Services (CPS).** CPS workers provide family services to reduce risk to children and to maintain them in their own homes. CPS cases are accepted for investigation based on a risk assessment which includes a sufficiency screen for new referrals, an initial risk assignment and response designation, and collateral contacts with key witnesses or information sources. CPS cases receive 24-hour intake, assessment, and emergency intervention services. Ongoing CPS include direct treatment, coordination and development of community services, legal intervention, and case monitoring. Family Assessment Response (FAR) is a differential alternative response for low to moderate risk screened-in reports of child maltreatment.
15. **Out-of-Home Placement** of a child indicate that the child was placed out-of-home with placement and care authority of the Department of Children Youth and Families (DCYF), including foster care, kinship care, or congregate care placements overseen by DCYF.
16. **DDCS Services** indicates receipt of various types of DDCS services based on service codes.
17. **Employed** includes individuals between the ages of 18-64 years.
18. **Developmental conditions** refer to the presence of any of the following: intellectual disability, language/learning disability, motor/tic disability, autism spectrum disorder, or chromosomal or congenital developmental disabilities. We used this measure to identify children of parents with IDD who had a developmental condition.

This definition is broader than the definition for IDD, since it includes language and/or learning disabilities, motor and tic disorders of development, and additional categories of pervasive disabilities.

19. **Dental Services** indicates that a Medicaid client received at least one dental service in the measurement year using ProviderOne dental claims information.

REFERENCES

Albert, S., & Powell, R. (2020). Supporting disabled parents and their families: perspectives and recommendations from parents, attorneys, and child welfare professionals. *J Public Child Welfare, 15(5):529.* doi: https://doi.org/10.1080/15548732.2020.1751771

Collings, S., & Llewellyn, G. (2012). Children of parents with intellectual disability: Facing poor outcomes or faring okay? *Journal of Intellectual & Developmental Disability*. *37*(1):65–82. https://doi.org/10.3109/13668250.2011.648610

Developmental Disabilities Administration. (2023). Report to Advocates and Stakeholders: 2023 Caseload and Cost Report retrieved from:

https://www.dshs.wa.gov/sites/default/files/DDCS/DDCS/documents/23-1149%20DDCS%20Caseload%20Report%20-%20Final.pdf

Dunn K., Kinnear D., Jahoda A., McConnachie A. (2019). Mental health and well-being of fathers of children with intellectual disabilities: systematic review and meta-analysis. *BJPsych Open*. Nov 7;5(6):e96. https://doi.org/10.1192/bjo.2019.75

Gómez L. G., Navas P., Verdugo M. Á., Tassé M. J. (2021). Empirically supported psychological treatments: The challenges of comorbid psychiatric and behavioral disorders in people with intellectual disability. *World Journal of Psychiatry*. 11(11):1039–1052. https://doi.org/10.5498/wjp.v11.i11.1039

LaLiberte, T., Piescher, K., Mickelson, N., Lee, M. H. (2024). The overrepresentation of parents with disabilities in child protection. *Children and Youth Services Review.* 158:107446. https://doi.org/10.1016/j.childyouth.2024.107446

Lauer E., Nicola N. D., Warsett K., Monterrey R. (2019). Contributions of mental and behavioral health conditions to health service utilization among people with intellectual and developmental disabilities in Massachusetts. *Inclusion.* 7(3):188–201. https://doi.org/10.1352/2326-6988-7.3.188

Lineberry, S., Bogenschutz, M., Broda, M., Dinora, P., Prohn, S., & West, A. (2023). Co-Occurring Mental Illness and Behavioral Support Needs in Adults with Intellectual and Developmental Disabilities. *Community Mental Health Journal*. 59(6):1119–1128. https://doi.org/10.1007/s10597-023-01091-4.

Lunsky Y., Balogh R. (2010). Dual diagnosis: A national study of psychiatric hospitalization patterns of people with developmental disability. *The Canadian Journal of Psychiatry.* 55(11):721–728. https://doi.org/10.1177/070674371005501106

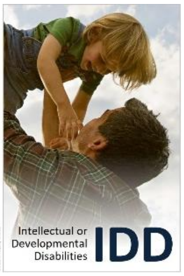
Mancuso, D and Huber, A (2021). DSHS Integrated Client Databases. DSHS Research and Data Analysis Division: Olympia, WA. https://www.dshs.wa.gov/sites/default/files/rda/reports/research-11-205.pdf

Namkung, E. H., Mitra, M., and Nicholson, J. (2019). Do disability, parenthood, and gender matter for health disparities?: A US population-based study. *Disability and health journal*, *12*(4):594–601. https://doi.org/10.1016/j.dhjo.2019.06.001

Randall K. N., Bernard, G., and Duarh, L. (2023). Association between employment status and quality of life for individuals with intellectual or developmental disability. *J Appl Res Intellect Disabil.* 36(2):270-280. https://doi.org/10.1111%2Fjar.13053

Ricciardi J. N. Co-occurring psychiatric disorders in individuals with intellectual disability. In: Reed D. D, DiGennaro Reed D.F., Luiselli JK, editors. *Handbook of crisis intervention and developmental disabilities.* Springer; 2013. pp. 213–243.

U.S. Census Bureau. (2023). 2022 American Community Survey 1-year Estimates Subject Tables retrieved from: https://data.census.gov/table/ACSST1Y2022.S1810?g=040XX00US53



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