EFFECTS OF ASYNCHRONOUS PROFESSIONAL DEVELOPMENT FOR RELIGIOUS LEADERS ON KNOWLEDGE AND CONFIDENCE IMPLEMENTING INCLUSIVE LANGUAGE AND LEARNING

by

Jared H. Stewart-Ginsburg

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Approved by:

_____
Dr. Valerie L. Mazzotti

_____
Dr. Erik W. Carter

_____
Dr. Robert C. Pennington

_____
Dr. Lyndon P. Abrams

_____
Dr. Claudia P. Flowers

ABSTRACT

JARED STEWART-GINSBURG. Effects of Asynchronous Professional Development for Religious Leaders on Knowledge and Confidence Implementing Inclusive Language and Learning (Under the Direction of DR. VALERIE MAZZOTTI).

Youth with disabilities are overall less engaged in extracurricular, community, and social activities than their peers without disabilities. Specifically, youth with intellectual and developmental disabilities (IDD; e.g., autism, intellectual disability) are less likely to participate in extracurricular or social activities compared to peers with other disabilities (e.g., learning disability; Lipscomb et al., 2017). Religious congregations may be one of the most prominent resources in rural communities (Institute for Emerging Issues, 2018) and underrepresented communities (Pargament, 1998) and can hold be an important resource for youth with IDD and their family members (Carter, 2021; Liu et al., 2014). However, leaders of religious congregations (e.g., clergy; religious education directors) may not know how to support and include youth with IDD in their congregation. This mixed method study measured the effects of an asynchronous professional development to train religious leaders in strategies for supporting youth with IDD in their religious congregations. Participants in the treatment group who participated in the professional development training demonstrated significantly higher scores in knowledge and confidence implementing Inclusive Language and Inclusive Learning than participants in the control group. Participants also identified opportunities, barriers, and implementation drivers to implementing Inclusive Language and Inclusive Learning in religious congregations.

Keywords: Inclusion in General Education, Intellectual and Developmental Disability, Religious Congregations, Interagency Collaboration, Community Experiences, Community-Based Instruction

DEDICATION

I dedicate this and offer my sincerest gratitude…

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TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

CHAPTER 1: INTRODUCTION

1.1 Statement of the Problem

From sport leagues to synagogues, civic choirs to culture clubs, and scouting troops to service groups, community activities can become important, enjoyable happenings in an individual's life. Participating in organized activities outside of school hours can promote self-esteem and prosocial development for students (Eime et al., 2013). For adolescents with disabilities, community experiences and involvement are associated with positive early adulthood outcomes (i.e., postsecondary education, employment; Carter et al., 2012; Mazzotti et al., 2016, 2021; Roessler et al., 1990; Test et al., 2009). youth with disabilities are 17 percentage points less likely to participate in extracurricular activities (81% vs. 64%; Lipscomb et al., 2017) compared to peers without disabilities. For activities organized outside of school (e.g., scouting, theater groups), the percentage is lower: 55% of parents raising individuals with disabilities reported their child participated in these activities versus 68% of peers without disabilities. Unsurprisingly, youth with disabilities are overall less socially engaged outside of school than their peers without disabilities (Lipscomb et al., 2017). These differences are present for both face-to-face and virtual social support, as 52% percent of youth with disabilities reported getting together with their friends at least weekly, compared to 66% of youth without disabilities. In addition, youth with disabilities are less likely to say they communicate with their friends via text messaging (54%, versus 67% of youth without disabilities) and social media (43%, versus 50% of youth without disabilities (Lipscomb et al., 2017). Across diagnoses, youth and young adults with intellectual and developmental disabilities (IDD; e.g., autism, intellectual disability) are less likely to participate in extracurricular or social activities compared to peers with other disabilities (e.g., learning disability; Lipscomb et al., 2017).

1.2 Promoting Community Experiences and Involvement

To encourage positive outcomes, the Individuals with Disabilities Education Improvement Act (IDEA, 2004) mandates the provision of transition services that promote postsecondary employment, education, and independent living for adolescents with disabilities. In the secondary transition process, the student's individualized education program (IEP) team coordinates transition services (e.g., vocational rehabilitation, course of study) to help the student achieve their post-school goals (IDEA, 2004). Coordination may involve personnel or services within the school system (e.g., coursework), referred to as intra-agency collaboration (Bumble, 2019). However, teams may coordinate services provided by agencies outside the school system (e.g., work experiences), referred to as interagency collaboration (Rowe et al., 2015). Collaboration patterns indicate secondary transition practitioners may not actively promote community involvement for youth with disabilities through their partnerships. Bumble (2019) surveyed 509 secondary transition practitioners to examine stakeholder collaboration in the transition planning process, both inside and outside the school system. Partners were categorized in three subnetworks: (a) school system (e.g., school counselor), (b) service (e.g., vocational rehabilitation), and (c) community (e.g., local employer). The average network size was 17.2 partners, but the average network contained only 3.3 community partners (i.e., not part of school or disability service systems). Local employers, vocational training programs, and two-year colleges were the most frequently mentioned partners. Depending on the type of partner, between 44.2% and 84.7% of participants indicated they did not know anyone in community networks except for local employers, vocational training programs, and two-year colleges. Other community organizations (i.e., religious congregations, local government, recreation or social

organizations, service organizations, transportation providers) were listed as partners for fewer than 30% of participant networks (Bumble, 2019).

For participants who collaborated with community organizations, religious congregations were the most frequently listed partners not explicitly related to postsecondary education or employment (29.3%). This is not surprising given religious congregations have been listed as an important community experience element in transition planning and services (Kohler et al., 2016). Religious congregations such as mosques, synagogues, and churches may be mainstays of communities that can play an important role particularly in: (a) historically marginalized communities where families may be more trusting of informal organizations (e.g., religious congregations, community centers) than formal institutions (e.g., mental health services; Harris et al., 2019; Pargament et al., 1998); and/or (b) rural and remote communities with otherwise limited agencies (Institute for Emerging Issues, 2018; Balasanduram, 2007).

1.3 Promoting Support in Religious Congregations

Parents raising children, youth, and young adults with disabilities reported religious congregations often do not provide supports and opportunities necessary for youth and young adults with disabilities to participate in congregational life (e.g., accommodations, modifications; Ault et al., 2013b; Ekas et al., 2009). For example, parents raising children with intellectual disability (ID) or autism perceived religious belief and expression as a helpful factor in raising their child, but reported varied perceptions toward the helpfulness of participating in a religious congregation (Ault et al., 2013a; Ekas et al., 2009). Parents raising children and youth with disabilities sometimes experienced what they perceived as barriers to participation in religious congregations, which included a perceived lack of knowledge about disability, unwelcoming attitudes, lack of supportive leaders, and unwillingness of the faith community to make

accommodations and provide supports (Ault et al., 2013b; Howell & Pierson, 2010; Jacober, 2010). Carter, Boehm, et al. (2016) explored supports religious congregations provide that were perceived as helpful by parents raising children with ID and autism. Authors also examined the availability of supports, responsiveness of religious congregations to individuals with ID or autism, and which factors (e.g., parent support groups, respite care, family advocates) were associated with this responsiveness. Parental perceptions of overall support were significantly, positively correlated with the availability of these individual supports (e.g., family resource center). Parents ranked the helpfulness of most supports higher than their availability (Carter, Boehm, et al., 2016).

Attendance and participation patterns in religious congregations support this finding. Across three waves of the National Children's Health Survey (2003–2012), Whitehead (2018) found that children with chronic health conditions (including IDEA [2004] disability categories) were more likely to never attend religious services compared to children with no reported health conditions. This trend was stable over time, indicating that, nationally, participation in religious congregations did not significantly change (Whitehead, 2018). Further, conditions that affect social interaction and/or communication had the strongest association with disengagement in religious congregations. For example, the odds of never attending religious services are higher for children with autism (1.84) and developmental delays (which included ID in the first two waves; 1.36) compared to children with at least one chronic health condition (e.g., specific learning disability).

Despite these findings, religious expression and involvement can be an important activity for individuals with disabilities. Religious belief was identified as one factor that predicted positive quality of life outcomes for youth and young adults with ID and autism (Biggs & Carter,

2016; Boehm & Carter, 2019a, 2019b). Three hundred eighty-nine parents and caregivers of young adults with ID and autism completed questionnaires that measured (a) five quality of life indicators (i.e., autonomy and parent relations, school environment, psychological well-being, physical well-being, social support and peers) and (b) eight predictor variables (i.e., communication, challenging behavior, functional abilities, support needs, involvement in out-of-school activities, strength of religious faith, self-determination, strengths). High parental ratings on strength of religious faith predicted two quality of life outcomes: (a) autonomy and parent relationships (i.e., higher scores on items related to youth autonomy and quality of familial relationships; e.g., "Has your child been able to do the things that he/she wants to do in his/her free time?") and (b) support and peers (i.e., higher scores on items related to receiving social support from peer friends; e.g., "Has your child had fun with his/her friends?"). Involvement in community activities was found to be a significant predictor of both social and peer support (Biggs & Carter, 2016).

From a qualitative perspective, youth with disabilities listed faith and religion as factors in their lives that provided meaning and enjoyment (Liu et al., 2014; Kleinert et al., 2007; Shogren & Rye, 2005). Liu et al. (2014) investigated the role of religion in the lives of youth and young adults with ID or autism. Researchers asked participants questions that addressed dimensions of their religious belief and practice (e.g., *Do you pray? What is it like when you pray?*). Most participants described how their faith helped them accept themselves and others and make meaning of life and their disability. Of the 20 participants, 13 discussed participation in religious activities and conveyed they found participation meaningful. When participants attended religious activities, these activities mostly took place at segregated disability-specific programs (i.e., not inclusive settings involving youth with and without disabilities). All

participants had little to no involvement in the youth religious education activities sponsored by their religious congregation, and only two respondents mentioned participating in religious education in inclusive settings (Liu et al., 2014).

Support from religious congregation leaders (e.g., members of the clergy, religious education directors, staff members) may contribute to greater levels of support for individuals with disabilities in religious congregations and increased participation for these individuals. Given religious faith is one predictor of quality of life outcomes (Biggs & Carter, 2016), increased participation of individuals with disabilities could contribute to improved quality of life perception. Further, family members of people with disabilities who perceived religious congregations leaders as supportive and understanding were more likely to report overall satisfaction with their religious congregation (Carter, Boehm, et al., 2016) or higher levels of perceived support for people with disabilities (Griffin et al., 2012).

However, leaders of religious congregations may not have competencies necessary for supporting individuals with disabilities (Francis & Jones, 2015). Religious congregation leaders often do not receive adequate training in this area (Annandale & Carter, 2014; Francis & Jones, 2015; Stewart-Ginsburg et al., 2020). Leaders expressed hesitancy discussing issues related to disability (Francis & Jones, 2015) and supporting individuals with disabilities (Patka & McDonald, 2015; Stewart-Ginsburg et al., 2020). Further, seminaries and religious training institutions do not comprehensively prepare religious congregation leaders with these skills (Annandale & Carter, 2014). Religious leaders who received training on supporting individuals with disabilities were more likely to report feeling confident in their ability to do so (Stewart-Ginsburg et al., 2020).

In a similar manner, religion is still a relatively unexplored topic within special education research (Ault, 2010; Slocum, 2016; Stewart-Ginsburg & Kwiatek, 2020). Few intervention studies exist to demonstrate effective methods of promoting support for youth and young adults with disabilities in religious congregations (Slocum, 2016). Previous intervention studies addressed (a) community conversations and (b) generalizing an evidence-based practice to a religious setting. Carter et al. (2017) utilized a community conversations method with religious congregation members and leaders to increase overall community support for people with disabilities. Baggerman et al. (2015) investigated the effects of using a Tell-Show-Try-Apply coaching package for a religious education teacher to increase rates of opportunities to respond, opportunities to participate, and behavior-specific praise for a child with complex communication needs. No intervention studies addressed: (a) training and preparation of religious congregation leaders; (b) implementation of supportive strategies; and (c) student-level outcomes. An additional barrier to training religious congregation leaders to support individuals with disabilities is lack of environmental uniformity. All religious congregations engage in similar types of activities (e.g., worship services, religious education, social holiday gatherings), but specific routines can differ drastically (Pew Research Center, 2015).

1.4 Predictors of Post-School Success

Promoting understanding and implementation of the research-based secondary transition Predictors of Post-School Success may be one way to address this challenge. Test, Mazzotti, et al. (2009) identified variables in correlational literature associated with positive post-school outcomes for youth with disabilities. The authors identified high-quality secondary transition correlational research published between January 1984 and March 2009 that investigated relationships between predictors and three post-school outcome variables (i.e., postsecondary

education, postsecondary employment, independent living). Twenty-two articles with a total of 26,480 participants matched their inclusion and quality indicator criteria. These articles were analyzed for effect size measures to determine strength of the relationship. Authors identified 16 evidence-based indicators of positive post-school outcomes.

Next, Rowe et al. (2015) operationally defined each of the 16 predictors with a Delphi consensus-building method. Twenty-two experts in secondary transition (i.e., researchers, experienced practitioners) participated in a three-round nominal group technique process. This process resulted in an operational definition and essential characteristics of each predictor. The operational definition explains the practical meaning of the predictor (e.g., "Inclusion in general education requires students with disabilities to have access to general education curriculum and be engaged in regular education classes with peers without disabilities," Rowe et al., 2015; p. 120). The essential characteristics of each predictor serve as actionable steps to implementation (e.g., "Observe and assess integrated environment to identify and provide interventions for needed academic, social, behavior, and communication skills to ensure a conducive learning environment for all students," Rowe et al., 2015; p. 120).

Next, Mazzotti et al. (2016) expanded the Predictors by reviewing secondary analyses from the National Longitudinal Transition Study 2 (NLTS-2). Authors identified four additional factors that predicted post-school success and added evidence to previously identified Predictors for a total of 20 variables that predicted post-school success. In addition, Mazzotti et al. (2021) updated the evidence base for current Predictors and identified three new Predictors for a total of 23 Predictors. These 23 Predictors of Post-School Success are broad, systems-level factors that were operationalized with essential characteristics and can be implemented across environments (e.g., school systems, community agencies).

1.5 Implementing the Predictors of Post-School Success Across Environments

While evidence-based practices are designed to be implemented in prescribed environments (Horner et al., 2005), Predictors are broad factors designed to be implemented across a system of support. Despite the empirical validation of these 23 Predictors, little research has been conducted to explore the effects of implementing the Predictors within community organizations to increase overall support for youth and young adults with disabilities.

To address this lack of research, I conducted two focus groups with religious congregation leaders to elicit perceptions and determine relevance of the Predictors of Post-School success in religious congregations. Participants came to consensus on each of the 20 Predictors of Post-School Success identified by Test et al. (2009) and Mazzotti et al. (2016). Mazzotti et al. (2021) was in preparation when focus groups were held. Participants ranked three Predictors they believed were most relevant to typical programs in religious congregations. Participants selected Community Experiences (n = 7), Social Skills (n = 6), and Inclusion in General Education (n = 5) as the overall top three most relevant Predictors. Qualitatively, participants expressed strongest interest in receiving training in Inclusion in General Education. Further, this Predictor as operationalized and characterized by Rowe et al. (2015) most closely resembles the characteristics religious leaders needed in training (i.e., strategies to ensure youth and young adults with disabilities can access and participate in religious congregations; Francis & Jones, 2015; Patka & McDonald, 2015; Stewart-Ginsburg et al., 2020).

1.6 Purpose of this Study

Training religious congregations leaders may be a method of removing systemic barriers to participation for people with disabilities (Carter et al., 2017). Research is needed to measure the effects of training on ways to support for individuals with disabilities in religious

congregations. While youth and young adults with disabilities encounter barriers to participation in religious congregations, these barriers are most significant for individuals with diagnoses that affect cognition, communication, and behavior (Stewart-Ginsburg, 2020; Whitehead, 2018), such as IDD. Therefore, the purpose of this study is to investigate the effects of a professional development training (PD) on religious congregation leaders' knowledge and confidence implementing two essential characteristics of Inclusion in General Education, a Predictor of Post-School Success (Mazzotti et al., 2016, 2021; Rowe et al., 2015; Test, Mazzotti, et al., 2009). Specifically, this study aimed to answer the following research questions (RQ):

1. What are the effects of an online, asynchronous professional development (PD) training (i.e., ROLLING) on religious congregation leaders' knowledge and confidence implementing Inclusive Language and Inclusive Learning (i.e., two essential characteristics of Inclusion in General Education; Rowe et al., 2015)?
2. What opportunities, barriers, and implementation drivers do religious congregation leaders identify for supporting youth and young adults with IDD in religious congregations as a result of this training (i.e., ROLLING)?
3. How do religious congregation leaders perceive this training?

1.7 Significance

The study will contribute to the limited research on promoting support for individuals with IDD in religious and community organizations in several ways. First, this study will be among the first to explore an intervention for providing explicit training to religious congregation leaders on strategies to support youth with IDD. Next, this investigation will determine if PD results in an increase in religious leaders' confidence supporting individuals with disabilities in religious congregations. Finally, this investigation will extend previous

studies by determining if explicit instruction in one Predictor of Post-School Success assists participants in identifying opportunities for increasing support for youth and young adults with IDD in religious congregations. In addition, the intervention will investigate the social validity of PD for religious congregation leaders.

Definition of Terms

Autism: autism refers to a range of conditions characterized by (a) social communication and interaction differences; and (b) restrictive and repetitive behavior, interests, and activities (Autistic Self-Advocacy Network [ASAN], 2020). Each individual with autism possesses unique strengths and differences and may demonstrate additional characteristics including sensory sensitivity, attention and executive functioning differences, and inapt behavior (Johnson et al., 2007).

Community engagement: Community engagement encompasses two dimensions: (a) activities and (b) relationships. First, community engagement comprises voluntary participation in regularly attended activities unrelated to education or employment opportunities (e.g., sports teams, worship services, shopping; Carter et al., 2010). While participating in these activities, youth develop social and interpersonal networks (Halpern, 1985). *Community participation* and *community involvement* are similar terms utilized in the literature (e.g., Sanford et al., 2011). Engagement often connotes a civic dimension, where individuals work together to improve and solve problems within their community (i.e., proximal geographic area; Arnold et al., 2008).

Developmental disabilities (DD): Developmental disabilities (DD) are conditions typically present at birth that affect an individual's physical, intellectual, and/or emotional development (AAIDD, 2020). DD is a broad category of lifelong disability that

can be intellectual and/or physical. DD comprises lifelong conditions that affect (a) the nervous system, (b) sensory systems, (c) metabolism, and/or (d) human development. autism, cerebral palsy, Down syndrome, Fragile X syndrome, and ID are examples of DD (NICHD, 2020).

Intellectual disability (ID): ID is a disability typified by limitations in: (a) intellectual functioning (e.g., learning, reasoning, problem solving) following: (a) conceptual skills (e.g., language, literacy, number concepts), (b) social skills (e.g., interpersonal skills, social problem solving); and (c) practical skills (e.g., personal care, occupational skills; Schalock et al., 2021). The disability originates before the age of 22. Practitioners must consider (a) the individual's community environment and (b) cultural and linguistic distinctives in the way persons communicate and behave before diagnosis (AAIDD, 2020).

Interagency collaboration: Interagency Collaboration is "a clear, purposefully, and carefully designed process that promotes cross-agency, cross-program, and cross-disciplinary collaborative efforts leading to tangible transition outcomes for youth" (Rowe et al., 2015, p. 122).

Online, asynchronous instruction: Online, Asynchronous Instruction is an educational method where (a) course materials (e.g., readings, lectures, assignments, discussions) are access completely via the internet and (b) students do not interact with the instructor or classmates in real time (Riggs & Linder, 2016). Learners complete activities in a self-paced manner by accessing a variety of tools, including video lectures, readings, and assignments (Skylar, 2009). Online, asynchronous instruction is typically delivered

through a learning management system (LMS) that hosts materials (e.g., Instructure Canvas, Moodle; Louhab et al, 2020; Kite et al., 2020).

Predictors of post-school success: Predictors of Post-school Success are variables associated with positive outcomes for youth with disabilities in the domains of postsecondary education, employment, and independent living (Test et al., 2009). Predictors were identified through meta-analysis of effect size between the variable (e.g., Community Experiences) and the outcome area (e.g., education) in correlational studies (Mazzotti et al., 2016, 2021; Test et al., 2009).

Professional development: Professional development refers to educational experiences skills to improve their job performance (Mizell, 2010). Professional development in education should provide practitioners opportunities to learn and implement evidence-based practices and predictors (Mazzotti & Morningstar, 2014).

Religious congregations: Religious congregations are formal entities which (a) exist to bring people together as the primary means of accomplishing its purpose, (b) offer sacerdotal function, (c) conduct religious worship in accordance with beliefs and practices of a particular religious body (Louithan & Miller, 1994). This term is purposefully nonspecific so as to provide a broad definition for organizations that espouse variability in religious tradition. *Faith communities*, *congregations, churches, synagogues*, *temples*, *mosques*, and *parishes* are synonymous with religious organizations.

Religious congregation leaders: Religious organization or congregation leaders serve as principals and institutional representatives within and beyond religious congregations (Barentsen, 2016). Religious congregation leaders oversee religious activities, including

(a) worship, prayer, lifecycle, and holiday rituals, (b) religious education, and (c) pastoral care and counseling (Barentsen, 2016). Religious congregation leaders may be ordained or recognized as a member of the clergy (e.g., Francis & Jones, 2015) or a layperson (i.e., not ordained) who serves in a leadership capacity (e.g., Baggerman et al., 2015). Religious congregation who serve as members of the clergy or layperson staff members typically receive training at a seminary or graduate theological institution (e.g., Kleinert et al., 2010).

Transition practitioners: Transition Practitioners are professionals who prepare students with disabilities for adult life within the process of secondary transition (Blalock et al., 2003). While the process of secondary transition involves a "full range" (p. 215) of professionals, Transition Practitioners comprise roles that primarily support youth with disabilities: (a) special education teachers, (b) rehabilitation counselors, and (c) transition specialists (i.e., professionals who primarily coordinate transition services instead of directly providing services; Blalock et al., 2003).

CHAPTER 2: REVIEW OF LITERATURE

In-school and post-school outcomes for youth and young adults with disabilities are historically and consistently lower than outcomes of their same-age peers without disabilities (Lipscomb et al., 2017; Newman et al., 2011). The United States Bureau of Labor Statistics (USBLS; 2018) found on average fewer than one-third of working-age individuals with disabilities reported a job in the 2010-2012 period (32.0%) while over two-thirds of working-age individuals without disabilities were employed in the same period (72.7%). People with disabilities are more likely to work part-time and less likely to be involved in the labor force (BLS, 2018). Additionally, students and communities are still feeling effects from the Great Recession (USBLS, 2018). Compared to a decade prior, youth with IEP were just as likely to attend an IEP meeting and less likely to participate in key transition activities (e.g., work-based learning; Liu et al., 2017). People with disabilities are underrepresented in management and professional/technical jobs, and occupations with the highest job outlook for people with disabilities tend to be low-paying positions (USBLS, 2018).

Generally speaking, education and employment outcomes for people with disabilities in the United States improved over the past 40 years. Compared to prior nationally representative samples (e.g., Hasazi et al., 1985; Mithaug et al., 1985; Wehman et al., 1985), people with disabilities reported higher rates of gainful employment. For example, in 1985, 21.4% of students with disabilities held jobs (with 0% gainful employment; Wehman et al., 1985). In 2011, 91% of young adults with disabilities held jobs (with ~61% gainful employment; Newman et al., 2011). Similarly, youth and young adults report higher rates of postsecondary education enrollment (e.g., 31% in 1985 versus 60% in 2011) and independent living (e.g., 36% in 1985 versus 59% in 2011; Liu et al., 2017; Mithaug et al., 1985; Newman et al., 2011; Wehman et al.,

1985). These increases are most notable for women with disabilities. Increases are also most notable for young adults with social and communication diagnoses, specific learning disability, and mild ID (Baer et al., 2003; Newman et al., 2011).

While the education of youth and young adults with disabilities has improved over the past 40 years, there is still room to grow. Krane et al. (2010) noted 19% of people with disabilities graduate from college versus 27% of people without disabilities. Newman et al. (2011) analyzed the 5th wave of the NLTS-2 which followed students with and without disabilities up to eight years after finishing high school. They found 60% of youth with disabilities continued in postsecondary education within eight years after finishing high school (*M* = 7 months). Youth with disabilities were more likely to enroll in a two-year community college. Regardless of setting, 77% of students with disabilities said they attended post-secondary education consistently, 41% graduated, and 31% left without graduating. Authors noted a 17 percentage-point difference between college graduation rates for students with disabilities (34%) and students without disabilities (51%).

Employment of young adults with disabilities also significantly improved over the past 30 years. In 1985, Wehman et al. reported (a) 21.4% of young adults with disabilities held jobs, (b) no respondents with disabilities were gainfully employed (0%), and (c) only a small percentage of employed young adults with disabilities received benefits such as sick time (12%) and vacation time (24%). Sixty-nine percent of respondents attributed their inability to secure gainful employment as a result of inadequate opportunities or training. Almost three decades later, Newman et al. (2011) found that up to eight years after high school, 91% of young adults with disabilities were employed at some time since graduating high school. Further, authors found: (a) on average, the sample of young adults held an average of four jobs; (b) 67% of young

adults with disabilities were currently working full time or had been at their most recent job; and (c) 61% of young adults with disabilities received at least one benefit (e.g., sick time, vacation time). While 26% of employed young adults with disabilities said their employer was aware of their disability, only 7% of employers offered accommodations.

Although employment and education outcomes have improved significantly, these improvements were not reflected in living and social engagement outcomes for young adults with disabilities which did not significantly improve over the past 30 years. Independent living comprises all other aspects of an individual's life beyond postsecondary employment and education (e.g., place of residency, community activities; IDEA, 2004). In regard to residency, independent living outcomes for young adults with disabilities have improved, though not at the same rate as employment or education. In 1985, Mithaug et al. reported (a) 64% of young adults with disabilities lived with their parents/guardians, (b) 14% of young adults with disabilities lived in their own home or independently, (c) 50% of young adults with disabilities drove a car, and (d) 42% of young adults with disabilities were socially inactive. Sanford et al. (2011) found 35.7% of young adults with disabilities lived independently while 44.2% of young adults without disabilities lived independently. Newman et al. (2011) found 59% of young adults with disabilities lived independently, and 77% of young adults had driving privileges.

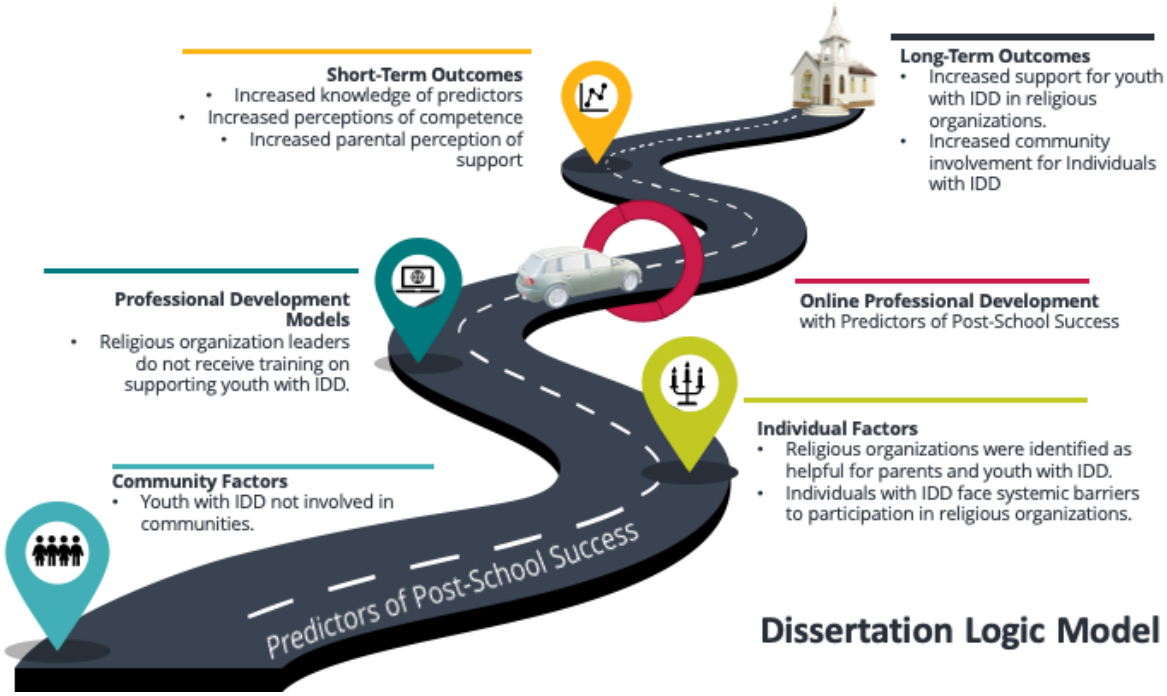
From a longitudinal perspective, young adults with disabilities typically reported lower levels of social engagement. Mithaug et al. (1985) classified 42% of young adults with disabilities as socially inactive, meaning participants reported they never interacted with friends or did so less than once a week. Raskind et al. (1999) asserted only 34.1% of young adults with disabilities participated in community activities and/or organizations. Similar to other outcomes, social engagement for individuals with disabilities has improved. Newman et al. (2011) reported

77% of young adults with disabilities had active friendships. Overall, 52% of young adults with disabilities participated in at least one type of community activity or experience over the past year. However, the percentage of participating young adults varied by type of activity, including (a) lessons or classes outside of school (19.6%), (b) a volunteer or community service activity (26.9%), (c) a community group (38.8%; Newman et al., 2011). Similarly, 64% of youth with an IEP participated in school-based extracurricular activities (e.g., clubs, sports) versus 81% of their peers without an IEP, and 74% of youth with an IEP participated in school or non-school activities (Lipscomb et al., 2017). While these percentages improved over the past decade, youth with an IEP are still significantly less likely to participate in community activities (Lipscomb et al., 2017).

The relatively stagnant trend in living and social engagement outcomes is concerning given participation in community activities was associated with positive (a) self-esteem outcomes (Kort-Butler & Hagewen, 2010); (b) college enrollment for young adults with developmental risks (Peck et al., 2008); (c) postsecondary degree completion for students with disabilities (Palmer et al., 2017); and (d) employment for youth and young adults with disabilities (Test, Mazzotti, et al., 2009). Further, youth with disabilities who participated in community experiences reported overall higher levels of life enjoyment (Biggs & Carter, 2016). The definition of community experiences is broad and comprises a variety of organizations (e.g., religious congregations, social clubs, civic associations, interest activities; Kohler et al., 2016; Rowe et al., 2015). Of these organizations, secondary transition practitioners most often collaborated with religious congregations (Bumble, 2019). Across disability categories, youth with disabilities who are affected by communication and cognition needs may be the most unengaged in community experiences and religious activities (e.g., Ault et al., 2013a; Richardson

& Stoneman, 2015; Whitehead, 2018). One reason may be a lack of training for religious leader in how to support youth and young adults with disabilities. Religious leaders identified inadequate training as a barrier to supporting youth and young adults with disabilities in religious congregations (Stewart-Ginsburg et al., 2020). One way to promote community experiences (and, thus, positive outcomes) may be to provide professional development for religious congregation leaders. However, few intervention studies exist in this area (Ault, 2010; Slocum, 2016). An exploration of strategies to support individuals with disabilities in religious congregations must consider several strands of literature which, together, form a framework for creating training opportunities that address perceived needs of community agency leaders. Therefore, this literature review comprises four strands, including (a) attaining inclusive community experiences, (b) characteristics of youth and young adults with intellectual and developmental disabilities (IDD); (c) religion and spirituality for individuals with IDD; and (d) professional development for community agency leaders. These four strands are explored in this chapter. Figure 1 serves as a guide for organization of the literature review. Literature strands are displayed as a roadmap to supporting individuals with disabilities in religious congregations, with strands serving as points along the road.

Figure 2.1. Logic Model of Professional Development for Religious Congregation Leaders



2.1 Theory and Research in Secondary Transition to Support Post-School Outcomes

Inclusive community experiences are activities or groups outside of school where youth and young adults with disabilities learn and apply skills and form friendships with peers without disabilities (Carter et al., 2013; Rowe et al., 2015; Test, Mazzotti, et al., 2009; Trainor et al., 2008). In considering methods for supporting youth and young adults with disabilities in attaining community experiences, it is first necessary to start with a historical view of the field of secondary transition. Over the past several years, researchers in secondary transition reviewed intervention research and identified evidence-based practices that help students with disabilities learn and maintain skills that prepare them for post-secondary education, employment, and independent living (e.g., McDowell, 2004; Test, Fowler, et al., 2009). Further, teams of researchers used correlational research to identify predictors (e.g., Mazzotti et al., 2021; Roessler et al., 1990) associated with positive post-school outcomes for students with disabilities in education, employment, and independent living. However, these practices and predictors hinge on an assumption of outcome relevance: the practices and predictors are effective as long as the outcomes they are associated with are socially valid (Trainor, 2017). More precisely, if practitioners, family members, and, most importantly, youth with disabilities do not value postsecondary education, employment, and/or independent living, practices and predictors to support these outcomes are inapt. To ensure equity for individuals with disabilities across various cultural and linguistic backgrounds, it is important to explore "what is valued, by whom, and to what end so we can understand how related resources are pooled, distributed, accessed, and used by all involved participants" (Trainor, 2017, p. 4).

Emergence of Secondary Transition

A historical view of secondary transition provides context for these outcomes. In 1980, the United States Congress repealed the Career Education Incentive Act for the subsequent fiscal year. This repeal opened up a block of grants for states to fund career development services, with some federal grants marked for individuals with disabilities (Hoyt, 1982). This was the first time the federal government provided specified funding for career development services for individuals with disabilities. Four years later, the Office of Special Education and Rehabilitation Services (OSERS) introduced the term secondary transition to describe these career development services (Will, 1983). Will (1983) outlined the "bridges from school to work" (p. 2) which involved three levels of services, depending on student need: (a) "transition without special services," (b) "transition with time-limited services," and (c) "transition with ongoing services" (p. 5). Initially, postsecondary employment was the only federal secondary transition outcome. This focus conveyed the complexity of helping individuals with disabilities obtain and hold gainful employment (Will, 1983). In rationalizing this focus, Will (1984) maintained that social, personal, leisure, and other adult roles enhanced opportunities to secure employment and appreciate the benefits employment offers. Further, Will (1984) asserted a focus on employment provides an objective measure of success for secondary transition services. Halpern (1985) suggested that instead of solely supporting employment, services outlined by Will (1983) should support community adjustment, or successful community living (Halpern, 1985). Halpern (1985) outlined three dimensions of community adjustment: (a) employment; (b) residential environment (e.g., quality of home and neighborhood, community services, recreational opportunities); and (c) social and interpersonal network (e.g., self-esteem, family support, friendship). While historically, employment, residential, and social/interpersonal outcomes were thought to be linked, Halpern reported insignificant correlations between employment status and

neighborhood quality (r = -.10), family support (r = .03), and social support (r = .00). Later, Roessler et al. (1990) confirmed these findings and reported that employment status was not associated with overall perceived quality of life for youth with disabilities. Throughout the 1980s and 1990s, the definition of secondary transition expanded to include services that promote the outcomes of community/independent living and social/interpersonal networks in addition to employment (Halpern, 1985; Halpern, 1992). As the decade drew to a close, practitioners and researchers began to conceptualize services supporting three different outcomes as one coordinated effort supporting all three outcomes.

Early initiatives of practitioners and researchers to implement secondary transition services were typically statewide and voluntary (Hasazi et al., 1985; Mithaug et al., 1985; Roesseler et al., 1990). Secondary transition found legal footing with the passage of the Individuals with Disabilities Education Act (IDEA) in 1990, which codified afederal legal mandate for secondary transition for youth with disabilities ages 16 and older as a series of coordinated services. The notion of planning secondary transition services evolved, and with it, the dimensions that school personnel and family members planned for, linked services to, and measured. IDEA (1990) mandated practitioners consider a student's preferences and interests in planning transition services. A planning statement was required starting when the student was 16 years, and transition services were considered activities that prompted movement from school to post-school environments. Further, services included the dimensions of (a) postsecondary education, (b) vocational training, (c) integrated employment, (d) independent living (IDEA, 1990). The 1997 reauthorization of IDEA added a required statement of needed transition services was amended to add related services and community experiences (IDEA, 1997, 34 CFR §300.29(a)(3)), as well as a statement of interagency responsibilities or needed linkages

(§300.347(b)(2)). The IDEA 1997 reauthorization changed the age of transition planning to 14 years with linkages beginning at age 16. The reauthorization also added parent participation as a requirement until the student reaches the age of majority (i.e., 18 years). Dimensions of outcomes remained unchanged.

Last, the 2004 reauthorization of the Individuals with Disabilities Education Improvement Act (IDEA, 2004) mandated IEP teams draft postsecondary goals for students as a component of the IEP to be in effect when the child reaches 16 years of age. Per IDEA, these goals must be updated annually, derived from age-appropriate transition assessment, and connected to students' strengths, preferences, interests, and transition needs. While secondary transition was originally an "outcome-oriented process" (IDEA, 1990, §602.30.A), the 2004 reauthorization of IDEA called for a "results-oriented process" (IDEA, 2004, §602.34.A). O'Leary (2005) noted the lingual transformation to a results-oriented process emphasized a focus on progress toward postsecondary goals rather than achievement. Dimensions of the results-oriented process comprise appropriate measurable goals in the areas of (a) training, (b) education, (c) employment, and (c) where appropriate, independent living skills. IEP teams must document evidence of extending an invitation to the student and representatives of participating agencies to join the IEP meeting where transition services are discussed (IDEA, 2004).

Research in Secondary Transition

As research and practice evolved, the field began to identify practices and strategies associated with improved outcomes. Over 30 years ago, Test et al. (1988) called for the field of secondary transition to move "beyond descriptive to a sound data base" (p. 2) by documenting effective strategies in program, workplace, family, and community settings. Subsequent studies acted on this suggestion by evaluating practices for teaching skills needed for postsecondary life

(e.g., Benz & Kochar, 1996; Hagner et al., 2012; Hughes et al., 1997). In 1999, Kohler and Chapman wrote the "empirical evidence for the effectiveness of individual practices is somewhat difficult to ascertain…at most, we can say there is guarded support" (p. 30). At the time of this publication, most evaluations were primarily focused on short-term outcomes (e.g., acquisition of a discrete independent living skill) rather than long-term outcomes (e.g., full-time employment). The authors acknowledged the need to examine findings over time. They outlined several research questions in the domains of (a) student-focused planning and development; (b) career pathways and contextual learning; (c) business, labor, and community resources; (d) family involvement; and (e) program structure and policies (Kohler & Chapman, 1999). This research later evolved into the Taxonomy for Transition Programming (Kohler, 1996; Kohler et al., 2016), which provided a framework for providing secondary transition services. Over the next decade, researchers in the field of secondary transition began to examine practices and factors associated with long-term outcomes (e.g., self-determination, work experiences, Career and Technical Education; Aspel et al., 1999; Baer et al., 2003; Everson et al., 2001; Goldberg et al., 2003; Geeneen et al., 2001; Raskind et al., 1999).

Since then, researchers and practitioners identified practices, predictors, and frameworks that have data-based evidence of effectiveness for promoting education, employment, and/or independent living. These included: (a) evidence-based practices designed to teach skills related to education, employment, and/or independent living (e.g., evidence based practices in secondary transition; Rowe et al., 2021; Test, Fowler, et al., 2009; Wong et al., 2015); (b) factors that predicted education, employment, and/or independent living outcomes (e.g., Predictors of Post-School Success; Test, Mazzotti, et al., 2009; Mazzotti et al., 2016, 2021; and (c) frameworks that outlined how secondary transition services can be implemented at state, local, and school levels

(e.g., Taxonomy for Transition Programming 2.0; Kohler, 1996; Kohler et al., 2016). While evidence-based practices vary depending on the outcome, domain, and student population (Test, Fowler, et al., 2009), strategies such as (a) promoting self-determination, (b) teaching self-care/independent living skills, (c) involving students in paid employment/work experiences (prior to exit from high school), and (d) supporting social and familial support are associated with positive outcomes across domains (Rabren et al., 2002; Test, Fowler, et al., 2009; Test, Mazzotti, et al., 2009). Still, further research is needed to identify and add evidence to emergent practices, predictors, and frameworks (Trainor et al., 2020).

Measurement of Post-School Outcomes

As local education agencies and states initiated career development services for individuals with disabilities, researchers were eager to document the long-term effects of these programs (Trainor, 2017). The focus in secondary transition research shifted from building programs toward evaluating programs and determining effectiveness, allowing researchers to identify characteristics of programs associated with positive post-school outcomes (e.g., Baer et al., 2003; Blackorby & Wagner, 1996). Measurement of post-school outcomes expanded in a manner and timeline that closely mirrored the changing definition of transition. Researchers utilized similar procedures over time to measure post-school outcomes, involving interview, survey, and questionnaire protocols. Initially, researchers measured post-school outcome in individual school districts (e.g., Levine & Edgar, 1994; Goldberg et al., 2003) and states (e.g., Repetto et al., 2002; Rabren et al., 2002). Later, researchers began to collect and analyze national samples of data as federal funding for transition services increased. The National Longitudinal Transition Study (NLTS; Blackorby & Wagner, 1996) was the first federally commissioned study exploring longitudinal outcomes of a nationally representative sample of youth with

disabilities. The NLTS followed 1900 youth with disabilities ages 13 to 21 years from 1985 to 1990 with two data collection points in 1987 and 1990. Over the five years of the study, the rate of competitive employment rose 11%, but youth and young adults with disabilities typically were more than 10 percentage points behind their peers without disabilities in employment rates.

Later, the NLTS-2 followed 4,650 youth ages 13 to 16 years receiving special education services in the 2000-2001 school year (Newman et al., 2011; Sanford et al., 2011). Researchers collected data from youth across five waves, ending in 2009. Overall, employment and education rates increased compared to the NLTS (e.g., 71% of young adults with disabilities reported having a paid job versus 43.5% in NLTS; Sanford et al., 2011). Last, the National Longitudinal Study 2012 (NLTS-2012; Lipscomb et al., 2017) probed 13,000 youth with disabilities and their parents on in-school outcomes and preparation for life after high school. Despite improvements in in-school outcomes compared to the NLTS and NLTS-2, youth with disabilities were still more likely to be economically, educationally, and socially disadvantaged compared to peers without disabilities (Lipscomb et al., 2017).

Earlier post-school outcome data collection included first the domains of employment and, later, postsecondary education, and independent living (e.g. Hasazi et al., 1985; Wehman et al., 1985). In subsequent decades, measured domains expanded to include quality of life indicators (e.g., job satisfaction; Sanford et al., 2011; peer support; Biggs & Carter 2016). Earlier data collection on quality of life outcomes primarily involved practitioners and caregivers (e.g., Halpern, 1985; Wehman et al., 1985). Researchers recently began to collect data from youth and young adults with disabilities (e.g., Carter & Boehm, 2019; Liu et al., 2014) and other family members (e.g., siblings; Carter et al., 2020; Hagiwara et al., 2018).

Quality of Life Outcomes

Most studies measuring longitudinal outcomes for youth and young adults with disabilities focus on the IDEA (2004) required areas of education, employment, and independent living. As a result, little is known about other dimensions of life for youth with IDD (e.g., quality of life, healthcare; Biggs & Carter, 2016). Understanding other dimensions may assist practitioners holistically support youth and young adults with IDD (Trainor, 2017; Turnbull et al., 2003).

In early studies on quality of life domains for youth and young adults with IDD, researchers identified self-determination as an important construct associated with quality of life outcomes. Wehmeyer and Schwartz (1998) found positive significant correlations between self-determination scores and total quality of life scores for a sample of 50 adults with ID ($r = .25$; $p = .04$). In Lachapelle et al. (2005), four components of self-determination were associated with positive quality of life outcomes (e.g., friendships) for an international sample of 182 young adults with ID, including (a) autonomous functioning (b) self-regulation, (c) psychological empowerment, and (d) self-realization ($p < .001$). Authors asserted the need for continued study of methods to promote quality of life and self-determination. Authors noted one component of self-determination is choosing activities meaningful to an individual, such as participation in community organizations (Lachapelle et al., 2005; Wehmeyer & Schwartz, 2005).

Biggs and Carter (2016) explored predictors of quality of life outcomes for transition-aged youth with IDD. They administered several assessments to 389 caregivers of transition-aged young adults (i.e., ages 13-21) with autism ($n = 232$) or ID ($n = 157$) in one southern state. The majority of caregivers identified as mothers (84.3%), college educated (56.4%), and married (71%). The majority of children they cared for were male (69.7%), White (80.7%), and did not qualify for free/reduced meals at school (63.9%). Assessments measured nine predictors: (a)

demographic variables, (b) disability characteristics, (b) communication, (c) challenging behavior, (d) functional abilities, (e) support needs, (f) involvement in out-of-school activities, (g) strength of religious faith, (h) self-determination, and (i) character strengths (e.g., courage, gratitude, humor). Caregivers completed the KIDSCREEN-27 (The KIDSCREEN Group Europe, 2006), a 27-item quality of life measurement. The KIDSCREEN assessed quality of life across five dimensions: (a) physical well-being (five items; e.g., "Has your child felt full of energy?"); (b) psychological well-being (seven items; e.g., "Has your child had fun?"); (c) autonomy and parent relations (seven items; e.g., "Has your child been able to do the things that he/she wants to do in his/her free time?"); (d) social support and peers (four items; e.g., "Has your child spent time with his/her friends?"); and (e) school environment (four items; e.g., "Has your child been happy at school?"). Authors used a multiple regression model to identify factors that predict quality of life outcomes (measured by overall scores in each domain). They found (a) autism negatively predicted psychological well-being (β = -2.34, $p < .05$) and social support (β = -3.75, $p < .05$); (b) minority ethnicity positively predicted physical well-being (β = 3.04, $p < .05$); (c) speech deficits negatively predicted school environment (β = -3.27, $p < .01$); (d) challenging behaviors negatively predicted school environment (β = -1.42, $p < .05$); (e) community activities negatively predicted social support and peers (β = .76, $p < .01$); and (f) strength of religious faith predicted autonomy (β = 1.56, $p < .01$) and social support (β = 3.08, $p < .01$). Strengths also predicted all quality of life domains ($p < .05$). Five factors did not predict any outcomes: gender of youth, qualifying for free or reduced meals, functional abilities, support needs, and self-determination. Authors suggested future research was necessary to explore and further characterize quality of life outcomes for youth with IDD.

Next, Walsh et al. (2017) examined the health care transition processes for students with autism to determine the extent that health was included as a relevant topic in the transition plan. They analyzed data from 1,125 adolescents ages 12 to 17 years (M = 14 years) collected in the 2009-2010 National Survey of Children with Special Health Care Needs (administered by the National Center for Health Statistics). The students were primarily white (71.1%) with similar samples of students whose autism diagnoses were categorized as mild, moderate, and severe. Researchers found that fewer than 10% of participants met the transition core outcome, which they characterized as a student discussing the following topics with a health care provider: (a) transitioning to an adult health care provider, (b) changing health care needs, (c) maintaining health insurance coverage, and (d) taking increased responsibility for their health care needs. The disparities were most pronounced in non-Hispanic Black youth, students from lower socioeconomic statuses, and students who did not engage in activities throughout the week, indicating general practitioner physicians and healthcare professionals were not discussing transition plans with students.

Interagency Collaboration in Secondary Transition

While secondary transition programs are primarily school-based, students with disabilities can learn and apply academic, social, and/or general work behaviors and skills outside the school setting (Rowe et al., 2015). Characteristics of a comprehensive transition program include supported, contextualized instruction (Kohler et al., 2016; Test et al., 1988) that can take place in the community wherever individuals with disabilities find valuable and advantageous (Carter et al., 2009; Tashie & Schuh, 1994). In addition to workplace skill acquisition, transition services should provide opportunities for community life and engagement (Benz & Kochlar, 1996). Opportunities identified in the literature included training in grocery

stores, retail stores, laboratories (Hughes et al., 1997), and internships (Luecking & Fabian, 2000). Transition practitioners can partner with agencies external to the school system (e.g., employment agencies) to promote employment and engagement (Carter et al., 2009). Students can learn and apply skills in places of employment, extracurricular activities, retail stores, and university classrooms (Bross et al., 2019; Hughes et al., 1997; Test et al., 1988) both during the school year and over the summer (Carter et al., 2009).

IDEA (2004) mandates the provision of secondary transition services as a "coordinated set of activities," that includes "instruction, related services, community experiences…" (§602.34.A). Thus, partnerships across agencies are essential for delivering secondary transition services. Apart from the legal mandate, it is essential to solicit representation across disciplines, stakeholders, and agencies to ensure the best process for students and feasibility of services (Blalock, 1996). This process is referred to as interagency collaboration. Literature demonstrated the importance of interagency collaboration. Test, Mazzotti, et al. (2009) identified small and medium correlations between interagency collaboration and both employment and postsecondary education for students with disabilities. In addition, Carter et al. (2009) found interagency collaboration created stronger linkages to employment for youth with disabilities and Mazzotti et al. (2021) identified interagency collaboration as a promising predictor of positive education and employment outcomes.

To understand how interagency collaboration is implemented, it is first necessary to understand the conceptualization of this term. Rowe et al. (2015) utilized a Delphi method to solicit input from transition practitioners and researchers, and defined interagency collaboration as "a clear, purposefully, and carefully designed process that promotes cross-agency, cross-program, and cross-disciplinary collaborative efforts leading to tangible transition outcomes for

youth" (p. 122). Findings from Rowe et al. (2015) provided essential characteristics of interagency collaboration as it is implemented in transition services, including (a) formal and informal agreements between responsible agencies, (b) asset/resource mapping to identify community agencies, (c) developing policies and procedures for school and community agencies delivering services and sharing, and (d) establishing multiple methods of communication and information sharing across agencies.

Interagency collaboration can take place at four levels: (a) student, (b) school, (c) community/regional, and (d) state. IEP teams pursue individualized transitions planning at the individual student level (IDEA, 1990; IDEA, 2004) by creating appropriate, measurable postsecondary goals based on the student's preferences, interests, strengths, and transition needs in education, training, employment, and, where appropriate, independent living. At this level, the IEP team identifies strengths, preferences, interests, and needs unique to the student. The team creates and implements individual services and goals for the student. At the school level, transition planning teams/committees lead curricular changes, extracurricular programs, and develop partnerships with agencies outside the school to serve students (e.g., vocational rehabilitation, religious congregation; Blalock, 1996; Flowers et al., 2018). These curricular changes, programs, and partnerships are essential for meeting collective needs of students at a school (Flowers et al., 2018). At the community and regional levels, community/regional transition teams coordinate interagency agreements and involve employers, related services, and community agencies (Blalock, 1996). These agreements and involvements maximize community opportunities for students (e.g., a place of employment agrees to provide a technical education program). At the state level, state teams (a) pursue interagency collaboration and agreements for all exceptional students in the state and (b) create a climate for successful interagency

collaboration in communities (Flowers et al., 2018). Johnson et al. (2003) outlined seven factors teachers believed were essential to support interagency collaboration: (a) commitment, (b) communication, (c) leadership from decision-makers, (d) understanding the culture and values of collaborating agencies, (e) engaging in serious pre-planning, (f) providing adequate resources, and (g) minimizing turf wars.

Evidence for Interagency Collaboration

Interagency collaboration is an effective process for supporting employment and education outcomes for students with disabilities. In their literature review, Test, Mazzotti, et al. (2009) identified interagency collaboration as a predictor of post-school success at the *potential evidence* level. Interagency collaboration correlated with higher rates of post-school employment and postsecondary education (r = .25–.45). Students who received support from three to six community organizations (versus zero to two organizations) were more likely to be engaged in post-school employment or education (Bullis et al., 1995). Similarly, students with disabilities were more likely to be engaged in postsecondary education when they (a) were involved in transition interagency council or (b) received support from transition service and support organizations (Repetto et al., 2002). Mazzotti et al. (2016) and Mazzotti et al. (2021) incorporated peer-reviewed literature on secondary transition predictors published after Test et al. (2009). They found no new evidence for interagency collaboration. However, Mazzotti et al. (2021) classified Interagency Collaboration as a promising predictor of education and employment outcomes using quality indicators of high-quality correlational research.

Papay and Bambara (2014) identified best practices for supporting education, employment, and independent living for youth with ID. They analyzed data from the second wave of the National Longitudinal Transition Study-2 (NLTS2) and measured the effect of seven

practices (including interagency involvement) on six outcomes: (a) employment, (b) involvement in postsecondary education, (c) enjoyment of life, and (d) social inclusion. All outcome variables were measured two and four years after youth finished high school. They found youth with ID who received interagency involvement were more likely to report higher levels of social inclusion two years after high school (odds ratio = 2.10, $p < .0125$) and higher levels of life enjoyment four years after high school (odds ratio = 12.35, $p < .0125$). However, youth with ID who received interagency involvement were less likely to be involved in postsecondary education (odds ratio = .07, $p < .0125$) and postsecondary employment (odds ratio = .46, $p < .0125$). Last, youth with ID were less likely to be involved in postsecondary education (odds ratio = .28, $p < .0125$) two years after high school and four years after high school. Authors theorized the variable interagency involvement may have actually measured the intensity of support needs of youth with ID, as youth with ID who have greater support needs may require more involvement from outside agencies (Papay & Bambara, 2014). Thus, they concluded, the relationship between interagency involvement and positive outcomes is complicated, and further research should more precisely measure the quality of involvement and services of agencies in the interagency collaboration process.

Communication Patterns in Interagency Collaboration

Williams and O'Leary (2001) sought to determine the efficacy of implementation for programs receiving Part B transition grants from the Office of Special Education Programs between 1993 and 1997. They found most state and local agencies appeared to deliver transition services without the benefit of external agencies. Special education teachers were often unaware of the services provided by community agencies. Authors suggested that explicit training be provided to (a) secondary transition practitioners on strategies for inviting and involving outside

agencies in secondary transition and (b) outside agencies on partnering with school districts to supports students with disabilities.

Plotner et al. (2017) studied perceived understanding of stakeholder roles in the transition planning process. They distributed a web-based survey and examined data from 427 participants who served as direct-service transition professionals and special education teachers. Participants answered questions about (a) perceived understanding of stakeholder roles in the transition planning process and (b) frequency of stakeholder communication. Further, authors analyzed the relationship among role perception, communication frequency, and collaboration level through (a) Pearson's correlation and (b) a Path analysis model to identify constructs of interagency collaboration. Overall, direct service transition professionals demonstrated higher levels of (a) role understanding (M = 3.68, SD = .57; vs M = 3.24, SD = .83); (b) frequency of communication (M = 3.82, SD = .43; vs M = 2.70, SD = .95), and (c) level of collaboration (M = 3.75, SD = .53; vs M = 2.89, SD = .95) than high school special education teachers. Authors found significant positive correlations between (a) frequency of communication and understanding of roles (r = .36, p < .01), (b) frequency of communication and level of collaboration (r = .84, p < .01), and (c) understanding of roles and level of communication (r = .35, p < .01). Further, role understanding and communication frequency were direct paths to levels of collaboration (p < .01), indicating communication and understanding of stakeholder roles are necessary to increase collaboration. To increase role understanding and communication, authors identified the need for developing effective methods of communication and culturally responsive transition communication strategies.

Similarly, Bumble (2019) explored the transition networks of 509 middle and high school special educators in one southeast state. Three hundred forty-two participants primarily

supported students with mild disabilities and 157 participants primarily supported students with moderate/severe disabilities. Respondents provided (a) partners they collaborated with; (b) communication frequency with each partner; (c) communication patterns for each partner (i.e., who initiated communication); and (d) communication perceptions (i.e., communication contributed to improved outcomes; preferences for future communication). Partners were categorized in three sub-networks: school system, service, and community. Members of the school system sub-network were directly employed by the school, district, or local education agency (e.g., speech language pathologist, school nurse). Members of the service sub-network comprised disability-specific agencies that provided service(s) that individuals qualified for based on a disability (e.g., vocational rehabilitation; social security). Members of the community sub-network represented agencies that offered services and/or opportunities to individuals with and without disabilities (e.g., local employers, local transportation providers).

Bumble found the average transition network included approximately 17 partners, with 10.8 school system partners, 3.1 service system partners, and 3.3 community partners. Some respondents indicated they did not know anyone from service (10.0%) and community (12.2%) subnetworks; 17.5% of special educators reported networks without service system and community partners. The most common community sub-network partners were (a) local employers (43.2%), (b) vocational training programs (37.9%), and (c) two-year colleges (33.0%). Aside from these three partners, between 44.2% and 84.7% of respondents indicated they did not know any partners in the remaining roles (e.g., recreation, Chamber of Commerce). Faith communities (e.g., churches) were the most frequently mentioned community sub-network partner not related to education or employment (29.3%). Compared to teachers who primarily supported students with mild disabilities, teachers who primarily supported students with

moderate/severe disabilities reported: (a) significantly larger transition networks overall ($F_{[1, 507]} = 21.06$, $p < .001$, $R^2 = .04$); (b) significantly more school system partners ($F_{[1, 507]} = 16.60$, $p < .001$, $R^2 = .03$); and (c) significantly more service system partners ($F_{[1, 507]} = 38.68$, $p < .001$, $R^2 = .07$). Further, teachers who primarily supported students with moderate/severe disabilities reported faith communities as a partner (40.1%) more often than teachers who primarily supported students with mild disabilities (24.0%).

Overall, partners communicated more frequently with stakeholders in the school and service sub-networks than community sub-network. Transition caseload, years working in the district, years of transition experience, and perceived level of administrative support were positively associated with transition network size. Respondents who reported higher self-reported knowledge of how to establish collaborative partnerships within systems were likely to have a larger network size. The author suggested the necessity of (a) creating interventions to encourage participation from a wide range of partners in the transition process and (b) understanding how student disability labels and belonging to historically marginalized groups may affect transition networks.

Summary

Despite significant improvement, in-school and post-school outcomes for youth and young adults with disabilities remain lower than their peers without disabilities (Lipscomb et al., 2017; Newman et al., 2011). Secondary transition is the outcome-oriented process of preparing youth and young adults with disabilities for adult life (Halpern, 1996; IDEA, 2004). Measured outcomes increased over the past four decades to reflect a more holistic view of students (Biggs & Carter, 2016; Halpern, 1985). Current legislation requires planning for and measurement of postsecondary education, employment, and independent living (IDEA, 2004). As the secondary

transition field progressed, researchers pinpointed practices (e.g., Test, Fowler et al., 2009) and predictors (Test, Mazzotti, et al., 2009) associated with positive post-school outcomes. Two such predictors were community experiences, which are non-school activities where youth with disabilities can practice academic, behavior, and work skills, and interagency collaboration, the process of partnering with agencies to deliver transition services (Mazzotti et al., 2021; Rowe et al., 2015). Transition practitioners mostly utilize agencies and stakeholders within the school and service system as partners in their transition service network (Bumble, 2019). Outside agency involvement is necessary to help students with disabilities attain inclusive community experiences (Rowe et al., 2015). Stronger interagency collaboration networks may be needed to promote inclusive community experiences and community involvement for youth and young adults with disabilities (Plotner et al., 2017). Training for secondary transition practitioners and community organization leaders may be necessary to increase support for youth with disabilities in community organizations (Williams & O'Leary, 2001).

2.2 Adolescents with IDD

Characteristics of Adolescents with IDD

IDD refers to a broad category of conditions typically present at birth that affect an individual's physical, intellectual, and/or emotional development (AAIDD, 2020). IDD comprises lifelong conditions that affect (a) the nervous system, (b) sensory systems, (c) metabolism, and/or (d) human development. While intellectual disability (ID) and autism are the most common types of IDD, cerebral palsy, Fragile X syndrome, and Down syndrome are also included under the category of IDD (NICHD, 2020).

ID originates prior to the age of 18 and is characterized by deficiencies in (a) cognitive processing; and (b) adaptive behavior, expressed in social, practical, and conceptual skills

(Luckasson et al., 2002). For identification, youth with ID must have: (a) limitations in present functioning (considered within typical environments for the individual's peers and culture); (b) valid assessment results considerate of culturally and linguistic distinctions in communication, sensory, motor, and behavior factors; and (c) the assumption there will be an improvement of general life functioning of the individual as a result of appropriate personalized supports over a sustained period of time (Schlock et al., 2007). From an education perspective, IDEA (2004) mandates students receiving services under the ID category must perform significantly below average in intellectual functioning with existing concurrent deficits in adaptive behavior.

Recent progressions in psychological diagnostic criteria (e.g., Diagnostic and Statistical Manual of Mental Disorders [DSM-5]; American Psychiatric Association [APA], 2013) dictate the consideration of clinical and standardized intelligence and cognitive tests (e.g., Wechsler Individual Achievement Test; Weschler, 2009) and adaptive behavior testing (e.g., Vineland Adaptive Behavior Scales; Sparrow et al., 2016). From a psychological standpoint, individuals with ID score at least two standard deviations below the mean on intelligence measures (e.g., IQ score of 70 or below) and demonstrate significant deficiencies in adaptive behavior (e.g., daily living skills; APA, 2013; Tassé et al., 2012). ID is typically classified as mild (i.e., IQ score ranging between 55 and 70), moderate (i.e., IQ score ranging between 40 and 55), or severe (i.e., IQ score below 40; Schalock et al., 2021). Individuals with ID may need varying levels of support and assistance across environments to function independently (Westling et al., 2015).

Autism is also classified as an IDD, as autism typically manifests during the developmental period. Clinical and educational understandings of autism significantly evolved over the past several decades (APA, 2013). Individuals with autism demonstrate high variability in characteristics due to the unique neurology of the diagnosis (Hazlett et al., 2017). IDEA

(2004) classified autism as a developmental disability that (a) affects verbal and nonverbal communication and social interaction, (b) is typically evident before age three, and (c) adversely impacts a student's educational performance. Diagnostic criteria include: (a) differences in social communication and social interaction across multiple contexts (e.g., nonverbal communication, developing relationships); (b) repetitive patterns of behaviors, interests, and/or activities; and (c) characteristics exhibited in the early developmental period (which may not be recognized until the child is older; ASAN, 2020; APA, 2013). Youth and young adults with autism often benefit from explicit instruction in and opportunities to practice social, communication, and daily living skills (Chiang et al., 2017). As mentioned, IDD comprises several additional diagnoses, including Fragile X syndrome, Down syndrome, and other disabilities that manifest during the developmental period (i.e., before the age of 22 in the United States; AAIDD, 2020).

In-School and Post-School Outcomes for Adolescents with IDD

While overall in-school and post-school outcomes improved for individuals with disabilities, a closer look at extant data reveals several exceptions. In-school and post-school outcomes for young adults with moderate or severe IDD do not share the same rate of improvement in education and employment outcomes compared to youth living with other disabilities.

In-School Outcomes

Youth with IDD continue to experience fewer positive outcomes than youth without disabilities and youth with an IEP. First, 72% of youth with ID live in homes with low socioeconomic status and 71% of youth with ID have an employed parent (Lipscomb et al., 2017). Both percentages are significantly lower than average for youth with an IEP. Youth with IDD are about half as likely to have a paid job while in high school (22–33% for youth with IDD

versus 40% average for youth with an IEP) or take a college entrance test (16–29% of youth with IDD versus 42% average for youth with an IEP; Lipscomb et al., 2017). Parents of youth with IDD are less likely to expect their children to live independently (35-49% of youth with IDD versus 78% average of youth with an IEP) or complete postsecondary education (32–53% of youth with IDD versus 61% average of youth with an IEP). Socially, youth with autism or ID are overall less likely to report getting together with friends weekly and less likely to participate in school sports and clubs (10 to 36 percentage points less than average for youth with a disability; Lipscomb et al., 2017).

Post-School Outcomes

Post-school outcomes for youth with IDD follow similar trends as in-school outcomes. Bouck (2012) analyzed a subsample of the NLTS2 involving 58,167 young adults with moderate or severe ID. They found 69.2% of participants were not employed in a paid job and 56.6% had not worked a paid job since high school. For employed young adults with moderate or severe ID, 87.5% worked part time, and 83.7% earned at or above minimum wage. There was no significant relationship between the type of curriculum the participant received in high school (i.e., functional, academic) and outcome variables (i.e., postsecondary employment, education, independent living). In addition, 6.6% of young adults with moderate or severe ID attended postsecondary education, including vocational school, 2-year college, and 4-year college (Bouck, 2012). College graduates with autism reported underemployment and chronic unemployment (Henninger & Taylor, 2013).

In addition to employment and education outcomes, these trends are present in independent living outcomes as well. Bouck (2012) identified that 3% of young adults with a moderate/severe ID were not living independently. Newman et al. (2011) found overall

community participation was lowest for individuals with (a) Autism Spectrum Disorder (autism; 49.0%) and (b) ID (formerly mental retardation; 46.7%). Further, students with these diagnoses reported among the lowest rates of participation across all subcategories of community activities. Only 17% of students with autism lived independently, compared to 51% of students with speech/language conditions, 58% of students with other health impairments, and 65% of students with specific learning disabilities (Newman et al., 2011).

Across correlational reviews, researchers identified several factors associated with improved outcomes for youth with IDD. Researchers found (a) high school work experiences predicted employment (F = 2.70, p < .001, Carter et al., 2012; r = 3.28, p < .05, Daviso et al., 2016), (b) inclusion in general education predicted postsecondary education enrollment (r = 1.94, p = .004, Baer et al., 2011; r = .47, p = <.001, Flexer et al., 2011); (c) career and technical education predicted fulltime employment (r = .38, p = <.001, Flexer et al., 2011), (d) having a case manager predicted independent living for youth with autism (r = .24, p < .05, Myers et al., 2015); (e) vocational skill instruction predicted employment (F = .13–67.48, p < .05, Park & Bouck, 2018); (f) conversational skills and functional skills predicted postsecondary 3education and employment (F = 1.1–16.3, p < .05, Shattuck et al., 2012), (g) family expectations predicted employment (F = 6.48, p <.001).

Summary

IDD is a broad category of diagnoses comprising conditions that affect physical, intellectual, and/or emotional development (AAIDD, 2020). Youth and young adults with IDD (specifically, ID and autism) experience fewer positive in-school and post-school outcomes in employment, education, and independent living, both compared to youth without disabilities and youth with other diagnoses (e.g., specific learning disability; Bouck et al., 2012; Lipscomb et al.,

2017; Newman et al., 2011). These outcomes have not improved at the same rate as outcomes for youth with disabilities across categories (Newman et al., 2011). Further, youth with IDD participate less in community experiences compared to youth with other diagnoses (Newman et al., 2011). While researchers have identified predictors associated with positive outcomes for youth with IDD, research is needed to identify interventions to increase community participation for youth with IDD (Bouck et al., 2012, Mazzotti et al., 2021).

2.3 Religion and Spirituality for Individuals with IDD

Since the beginning of written history, societies have attempted to answer existential questions through structured sacred rituals and narratives attributing events and occurrences to presence of supernatural or divine beings that existed beyond but interacted with the realm of humanity (Baumard & Chevallier, 2015). Defining religion and spirituality can be difficult, as conceptions inexorably mirror the theoretical alignment of the writer (Bowie, 2006). In essence, religion has been defined as "value-laden narratives and behaviors that bind people to their objectivities, to each other, and to non-empirical claims and beings" (Flood, 1999, p. 47). Systems of rituals are typically categorized as a religion, a term that operatively conglomerates both personal belief in divine being (often referred to as *faith* or *spirituality*) and public expression of that belief (often referred to as *religious involvement*; Pew Research Center, 2015).

Individuals who consider themselves members of a religion typically adopt a personal worldview based on the organized principles of that religion, which influence priorities, choices, activities, and relationships (van der Kooij et al., 2017). Religious adherents often participate in both private expressions of religion, such as communication with supernatural beings (e.g., prayer, reading sacred scripture), and public expressions of religion, such as community gatherings where rituals are performed (e.g., worship services; Baumard & Chevallier, 2015;

Pew Research Center, 2015). Religious involvement typically takes place in a religious congregation (e.g., synagogue, mosque, church) which exists to provide opportunity for and promote religious expression and involvement (Pew Religious Forum, 2019). Religion has shaped the landscape of the United States, as many towns and communities were established in proximity to or as a result of religious congregations (Library of Congress, 2020).

Although a religion typically emerges as a series of informal rituals shared by a small group of persons, many religious subsets have evolved to constitute hundreds of thousands of religious cognregations and millions of followers in the United States (Baumard & Chevallier 2015; Pew Research Center, 2019). Approximately 77% of Americans who responded to a nationally representative survey claimed some sort of religious affiliation, and the same percentage viewed religion as *very important* or *somewhat important* in their life (Pew Research Center, 2019). The Pew Research Center (2019) found 69% of Americans attested they attend worship services at *least a few times a year*, although consistent involvement in religious congregations has declined over the past several decades. The typical primary activities of religious congregations are worship services, which are gatherings held for the purpose of divine adoration and reflection. Religious congregations often offer opportunities for religious education, socialization, and community service (Pew Research Center, 2015).

Conceptualizations and trends describing religious expression and involvement are inherently reductive because they do not capture the mystical, spiritual, extraordinary, and profound aspects of religion that adherents describe as rationale for their religious devotion (Good, 1994). Religious congregations support this devotion by serving as focal points for communities to gather around shared purposes (Geertz, 1966). Bowie (2006) summarized the

quest for an empirical understanding of religion concisely: “Religion is not just ‘out there’ but simultaneously observed and experienced from within” (p. 23).

Religious Expression for Youth and Young Adults with IDD

Spirituality and religious expression can be important aspects of human experience, and persons with disabilities should have the opportunity to choose to express or not express this aspect in a manner they see fit (AAIDD and the Arc, 2010). However, youth and young adults with IDD may experience barriers to expressing religious belief or maintaining participation in a religious congregation. These barriers included unsupportive attitudes and misconceptions toward people with disabilities (e.g., refusing to teach a child with a disability; Jacober, 2010). Relatively little attention has been given to investigating the role that religion can play in the life of a child, youth, or adult with IDD (Ault, 2010; Slocum, 2016).

Understanding the role religion can play in the life of a person with IDD may be challenging due to the methodological difficulty involved in recording and measuring the ethereal, abstract, and personal beliefs of individuals who experience diagnoses that affect communication and/or cognition (AAIDD, 2010; Lewis, 2009). People with IDD may experience religion and spirituality in ways that align with the nature of their diagnosis, such as communication patterns and conceptualization of divine being(s) (Lewis, 2009).

Few inquiries have explored how people with IDD conceptualize and embrace religion and spirituality. Currently, only three data-based, peer-reviewed articles were identified that address this topic. Visuri (2018) conducted a qualitative inquiry to investigate conceptualizations and patterns of communication with unseen, superhuman agents for youth with autism. The author used an anthropological analysis framework to describe how participants assimilated into imaginary realities and if these communication patterns were helpful due to rehearsed social

cognition. Seventeen participants with autism ages 16 to 21 years participated in three rounds of inquiry: (a) self-report survey and psychometric tests, (b) creation of pictographic biographies with semi structured interviews, and (c) arrangement and exploration of pictographic biographies. Interviews were transcribed and coded using phenomenological thematic analysis with themes truncated and summarized. Visuri found the sample of youth and young adults with autism embraced religious and fictive beings as a form of developing emotionally and socially comprehensible interaction. Participants perceived bodiless agents as predictable, benevolent, and comprehensible. Particularly, participants appeared drawn to religion and supernatural mentalizing because of the divine beings that can be imagined in these contexts. The author called for continued attention in research and practice on the role and conceptualizations of religion and spirituality for adolescents with autism.

Youth and young adults with IDD also communicated dimensions of religious expression. Liu et al. (2014) investigated the role of religion for youth and young adults with ID or autism. The authors conducted semi structured interviews with 20 participants ages 13 to 21 years (M = 16.9), and transcribed, coded, and triangulated responses via field notes. Six participants identified as female and 14 identified as male. Researchers asked participants questions that addressed dimensions of their religious belief and practice (e.g., *Do you pray? What is it like when you pray?*). Participants described how their faith helped them accept themselves and others and make meaning of life and their disability. Nineteen participants affirmed a personal relationship and/or connection with God, which was expressed through daily prayer. Authors concluded practitioners should encourage and support youth and young adults with IDD to participate in activities youth find meaningful. Further, authors called for further exploration of religious experiences of youth and young adults with IDD.

Last, Carter and Boehm (2019) explored religious and spiritual expressions and involvement of youth and young adults with IDD. They surveyed parents of 440 youth and young adults with ID or autism (M = 16.4 years; range = 13–21 years) to determine frequency and dimensions of youth involvement in religious congregational activities (e.g., attendance at worship services) and spiritual practices (e.g., prayer). More than half of the youth had some degree of attending three religious activities daily/weekly, monthly, or yearly: (a) worship services (85.5%), (b) religious education classes (63.0%), and (c) congregational social gatherings (58.7%). Youth participated in fewer activities that involved service within or beyond the congregation (~20% or less). Youth who participated were most likely to initiate the activity (i.e., versus a family member; range = 53.1%–75.6%). Similarly, at least half of the youth participated to some degree in 11 personal spiritual practices, such as praying before or after mealtime (74.5%) or listening to/reading scripture (68.7%). Parents were more likely to have initiated spiritual practices than congregational involvement, but 6.4% of youth engaged in no spiritual practices. On average, parents perceived a moderate level of strength of religious faith for their youth (M = 2.62; SD = .90), and 57.0% of parents indicated their youth looked to their faith for meaning and purpose. Through regression analysis and bivariate correlations, authors found the autism label was strongly associated ($p < .01$) with fewer congregational activities (β = -.11), lower ratings for strength of youth's religious faith (r = -.10). Further, lower ratings for the youth's strength of religious faith were associated with higher support needs (β = -.12). Carter and Boehm asserted the importance religion and spirituality can have for youth and young adults with IDD and encouraged practitioners and ministry leaders to address the gap between interest and actual involvement.

In addition to religious expression, initial literature on quality of life factors appears to support the perception of religion as a potentially important factor by youth with IDD. In Biggs and Carter (2016), caregiver participants responded to a researcher-adapted proxy version of the Strength of Religious Faith Questionnaire – Short Form instrument (Plante & Boccaccini, 1997) and used a Likert scale to rate their agreement on five statements related to their child's faith. Researchers calculated a mean score; higher means indicated stronger religious faith. They found that for both young adults with autism and ID, higher scores on strength of religious faith predicted two quality of life domains: (a) social supports and peers ($\beta = 1.56$, $p < .001$) and (b) autonomy and parent relations ($\beta = 3.08$, $p < .01$).

Religious Involvement for Youth and Young Adults with IDD

Although several studies identified religious expression as a support to quality of life for youth and young adults with IDD (Biggs & Carter, 2016; Boehm & Carter, 2019b; Liu et al., 2014; Visuri, 2018), participation in religious congregations was sometimes described as less helpful to parents raising children with IDD (e.g., Ault et al., 2013b). Despite that youth with IDD indicated religious expression was important to them, religious involvement was described less frequently and in segregated settings exclusively from peers without disabilities (Liu et al., 2014). Additionally, religious congregations sometimes do not support children, youth, and young adults with IDD in their religious involvement (Carter, Boehm, et al., 2016).

In their qualitative investigation of religious expression for youth with IDD, Liu et al. (2014) also examined religious involvement for youth with IDD. Thirteen participants reported participation in religious activities and indicated they found participation meaningful. Aside from weekly worship services, when participants attended religious social activities, such as Sunday school, camp, or retreats, these activities almost always took place at segregated disability-

focused ministries and groups unaffiliated with the participants' home religious congregation. All participants had little to no involvement in the youth activities sponsored by their home religious congregation, and only two respondents mentioned participating in religious education in inclusive settings. Authors communicated the necessity of finding strategies to support youth with IDD in religious congregations.

Attendance data in religious settings appear to match these findings. Whitehead (2018) analyzed data across three waves of the National Survey of Children's Health (i.e., 2003, 2007, 2011–2012, respectively) to investigate the relationship between the presence of chronic health conditions and the trend of never attending religious services over time. The nationally representative survey was administered by the Centers for Disease Control and Prevention's National Center for Health Statistics and used complex sampling to collect data from phone interviews with 289,672 parents. Participants provided one data point indicating whether they had ever been told by a doctor or health provider that their child had a chronic health condition and one data point indicating the frequency their child attended religious services. All 13 categories of IDEA (2004) were included in the list of chronic health conditions. The author utilized regression models and controlled for survey year. Whitehead found that, compared to children with no reported health conditions, children with chronic health conditions were more likely to never attend religious services. The probabilities of never attending religious services were highest for children with autism (1.84) and developmental delays (which included ID in the first two waves; 1.36). In the final wave (2011–2012), ID was split into its own category. In this wave, children with ID were as likely to never attend religious services. The author concluded that diagnoses that affect social interaction and/or communication are most strongly associated with disengagement in religious congregations and theorized that attitudinal barriers (e.g.,

unwelcoming attitudes) may influence this trend. The trend was found to be stable over time, indicating that, nationally speaking, participation of children with chronic health conditions in religious congregations has not substantially changed.

Supporting Religious Involvement

As discussed previously, youth with IDD may experience systemic barriers to meaningful religious involvement with their peers without disabilities. Four studies examined methodologies for supporting religious involvement for individuals with IDD (Ault, 2010; Carter, Boehm, et al., 2016; Carter et al., 2017; Slocum, 2016). First, Ault (2010) explored the extent to which special educators are exposed to the topics of spirituality and religion. They reviewed 10 years of research published in journals received by Council for Exceptional Children (CEC) members and 16 CEC subdivisions between 1997 and 2008. They identified 69 articles with embedded or explicit references to religion and spirituality. Of the articles that addressed inclusion and support in religious congregations, no studies involved a child or youth as a research participant or indirect consumer. Many identified articles (n = 36; 52%) studied religious and spiritual diversity as it related to sociocultural backgrounds (e.g., Latinx families, Asian American families). More than 50% of the reviewed articles (n = 37; 54%) did not use a research methodology, but presented a theory or discussion on a religious topic (e.g., research synthesis on religious interpretation of disability).

Second, Slocum (2016) conducted an updated literature review on articles that explored inclusion of children and youth with ID in religious congregations. The inclusion criteria for the articles were: (a) specifically addressed including persons with ID in religious congregations, religion, or spirituality; (b) recommended strategies for promoting inclusion of individuals with disabilities in religious congregations; and (c) were published in a peer-reviewed journal found

in the EBSCOhost database. Dates were not specified for the review, and 22 articles were identified. Thirteen articles described a lack of meaningful inclusion in religious congregation. Four articles described case studies where religious congregations were engaged in intentional efforts to include children with disabilities (e.g., creating a disability-access committee; Collins & Ault, 2010). These case studies did not measure impact of the systems and programs but reported a mix of perceived successful and unsuccessful results. Five articles recommended that special educators provide training in creating inclusive environments to religious congregations (but did not outline what this training should comprise); and four suggested that seminaries include coursework on disabilities. The author concluded that (a) training religious congregation leaders is crucial in supporting individuals with IDD in religious congregations, and (b) research is necessary to demonstrate explicit educational strategies to make religious involvement accessible for people with IDD.

Next, Carter et al. (2017) addressed the challenge of creating supports by investigating the strategies and themes that emerge when religious congregations discuss promoting inclusion and belonging for individuals with disabilities. They conducted community conversations on this topic in two diverse counties. One hundred seventy-five participants attended forums in an urban community (n = 98) and suburban community (n = 77); participants identified themselves as various stakeholders within the religious congregation, including family members of a person with a disability (29.1%), disability service providers (18.3%), person with a disability (9.7%), clergy members (9.1%), and other congregation roles (55.4%). The authors served as forum moderators and posed three questions for attendees to discuss. Questions addressed what religious congregations could do to include and support persons with disabilities and their families, both in religious settings and other areas of life. A designated person recorded

responses to the questions. Participants recommended 984 individual discrete actions; the team of researchers used constant comparative methods and coded these ideas into 23 categories across five broad themes. Participants also answered a survey measuring their perception of the forum for social validity data.

The most common theme addressed (38.3% of responses) was disability-specific efforts, such as offering family supports (e.g., respite care, networking times), individual supports (e.g., congregational advocates, buddy systems), awareness efforts (e.g., disability awareness events, story sharing), and focused reflection and intentional teaming (e.g. needs assessment, accessibility audit). Internal activities were also frequently suggested (23.3% of responses), which addressed activities and events designed to foster connections among current religious congregation members. The authors considered the frequency of these responses, which included opportunities for individuals with disabilities to fellowship, participate, and serve in the religious congregation, to be a positive indication of the desire to reduce isolation experienced by individuals with disabilities (Carter et al., 2017). Actions that concern external activities (e.g., partnering with other congregations and ensuring accessible communication; 24.2% of all responses), influencers (e.g., welcoming disruption in services; 7.5% of all responses), and resources (e.g., transportation and facilities and buildings; 6.7% of all responses) were also proposed. Almost all participants who completed the survey agreed the event was a good investment of their time (97.8%) and identified steps they (91.2%) and their congregation (92.7%) could take to support inclusion in religious congregations. Researchers noted the absence of discussion regarding specifically including children and youth with disabilities, as well as theology and doctrine. Authors called for further research to measure implementation of ideas generated at the forum and long-term impact of these ideas.

Last, Carter, Biggs, et al. (2016) interviewed 25 parents raising youth with IDD and identified dimensions of belonging for youth with disabilities in religious congregations. Parent interviewees lived in one southeastern state and had a child with ID or autism between the ages of 13 and 21 (M = 17.1) and actively participated in a Christian religious congregation. Authors probed participants about characteristics of congregational involvement for their child and family. From participant interviews, they identified 10 characteristics parents associated with successful participation and satisfaction with their congregation. Authors described the 10 dimensions as ordinal levels of congregational support, where persons with disabilities are (a) present, (b) noticed, (c) welcomed, (d) cared for, (e) supported, (f) accepted, (g) known, (h) befriended, (i) needed, and (j) loved. Authors encouraged leaders in religious congregations to examine pathways to promote belonging for persons with disabilities in religious congregations using the dimensions as a guide. In addition, authors asserted the need for researchers to explore the salience of each dimension of belonging in the lives of people with IDD and steps to create pathways for individuals with IDD to access a sense of belonging (Carter, Biggs, et al., 2016).

Religious Expression and Involvement for Families of Individuals with IDD

The nature of religion dictates that participation is inherently a family activity. From birth rituals (e.g., baptism) to coming of age rituals (e.g., *b'nai mitzvah* ceremonies) to weddings to funerals, religious congregations assist in marking time at every life stage (Bowie, 2006). Because of this, family members play an important role in promoting and supporting religious involvement for youth with IDD. In addition to youth with IDD, religious expression and involvement was identified as a potentially important factor for parents raising youth with ID. Specifically, personal faith and religious belief were identified as supports to raising a child with IDD (Ault et al., 2013a; Ekas et al., 2009). Religious belief can assist parents and families in

celebrating and making meaning of their child's life (Balasundaram, 2007; Chang & Hsu, 2007). Faith can support parents in reframing the diagnosis and care routines as a meaningful, if unexpected, journey (Jegatheesan et al., 2010). Further, religious beliefs and constraints can affect a family's decision to receive early intervention and/or special education services (Dinora & Bogenschutz, 2018; Pearson & Meadan, 2018).

Studies have specifically examined the role that religion can play for parents raising children with disabilities (e.g., Howell & Pierson, 2010; Poston & Turnbull, 2004; Skinner et al., 2001). Balasundaram (2007) examined the relationship between religion and parental acceptance of a child's diagnosis. Parents identified with either Islamic or Hindu faith traditions. The author conducted semi-structured focus group interviews as part of a weekly support group with an undisclosed number of mothers raising young children with ID in a colony in South Delhi, India. The mothers expressed that as symptoms related to their child's diagnosis did not improve, they continued to lose faith and trust in their God. Common themes included: (a) the belief their situation was *karma* at work (i.e., previous actions in this and previous states of existence determined fate in this and future existences); (b) viewing their situation as a punishment; (c) discouragement when the *pujari* (priest in the Hindu temple) said their children would improve and they did not; and (d) losing faith in God as caring for their children became more of a stressor. Despite these beliefs, many of the mothers said that over time they came to believe divine being(s) gave them strength. This ostensible paradox was a theme that consistently emerged from mothers' responses.

Similarly, Luong et al. (2009) conducted interviews with nine parents raising children with autism. The study was designed to determine and understand their coping mechanisms. The eight mother participants and one father participant who were first-generation Southeast Asian

immigrants to the United States, were raising children between the age of three and 10 years, and identified as either Buddhist or Catholic. All nine participants expressed they used religious practices to cope with their child's diagnosis, which they found beneficial. "Religious practices, such as simple praying at home, recharged their hope" (p. 227), and spirituality helped them to feel a sense of purpose. Authors encouraged practitioners who support families raising children with disabilities to nurture spirituality when important to the family and encouraged researchers to explore ways to promote religious practices as coping mechanisms for parents.

In another study, White (2009) investigated the characteristics of religious involvement for parents raising children with autism. Most of the 177 participants were mothers (87%); their children ranged in age from two to 31 years (M = 9 years). White found that parents who reported higher levels of religiosity (a) were more accepting of their child's diagnosis and (b) demonstrated higher levels of perceived well-being. However, the parents found both positive and negative aspects of religious involvement. Negative aspects of religious involved barriers to involvement in religious congregations for children with autism and their parents, such as clergy members discouraging parents from bringing their child to worship services. White identified several important supports that a faith community could provide to help families of children with autism participate, including having leaders who carried a "perspective of openness and acceptance" (p. 112) and encouraged families raising children with autism to participate in the religious congregation.

Similarly, Boehm and Carter (2019a) explored the spiritual and religious lives of 530 parents and caregivers of youth with ID in two states in the United States. Most participants were mothers (86.0%), but other relationships included fathers (8.5%), siblings (2.6%), grandparents (1.5%), aunt/uncle (0.4%), or another role (0.9%). Participants described: (a) their family's

congregational involvement; (b) religious/spiritual beliefs, practices, and social support; and (c) strength of religious faith. The majority of participants (90.8%) identified with a religious tradition, and 8.3% did not. Parents and caregivers listed 36 distinct religious traditions; most were Catholic or Protestant Christian. On average, participants involved in a religious congregation had attended for 13.9 years (range = 0–80 years). Worship service attendance varied and was not correlated with family member's severity of disability, age, or challenging behaviors. Most family members (70.2%) participated in at least one of 13 activities at least once or twice a month (M = 1.5 activities) or at least several times a year (e.g., attending religious education, serving as an usher/greeter; M = 3.1 activities). Participants most often took part in sacraments (56.3%) and social gatherings (49.4%), but took part less often in volunteer or service roles, such as serving on a music team (11.7%) or as an acolyte (8.6%).

Overall, participants demonstrated overall agreement with items concerning spiritual and religious beliefs and practices (e.g., "I feel certain that God in some form exists"; M = 3.24, SD = 0.79). Most participants somewhat agreed or strongly agreed their religious belief has provided hope (82.9%), religious belief is important in their daily lives (78.2%), they enjoyed being around others who share their faith (81.9%), and they enjoyed attending religious functions (72.9%). However, fewer participants indicated they considered themselves actively involved in their faith or congregation (59.8%) or seek out people in their religious community when they need help (35.5%). Religious beliefs, practices, and strength of religious faith were not significantly correlated with their family member's age, disability severity, or challenging behaviors. Lower ratings of religious/spiritual social support were significantly correlated with higher disability severity ratings (r = -.10, p = .01) and ratings of more challenging behaviors (r = .12, p = .02; Boehm & Carter, 2019a). Authors concluded that spirituality and religion held a

prominent place in the lives of most participants, and participants varied widely in the frequency, type, combination, and practices of religious expression and involvement. Similarly, spirituality and religious participation may contribute to quality of life experienced by these parents and caregivers. Authors suggested increased engagement of faith communities to actively support family members of children and youth with ID (Boehm & Carter, 2019a).

In addition, Boehm and Carter (2019b) explored the relationship between religious involvement and perceived family quality of life within the same sample as the previous study (Boehm & Carter, 2019a). Religious and spiritual factors (e.g., "Prayer or meditation has helped me cope during times of serious stress", p. 104) added 3.0% explanatory factor for the model (change in $R^2 = .03$, $p < .001$) and accounted for 36.4% variance in parents' satisfaction ratings ($R^2 = .36$, $p < .001$). While greater overall religiosity/spirituality was correlated with higher family quality of life ratings ($r = .23$, $p < .01$), frequency of congregation attendance was not ($r = -.10$, $p > .05$). Overall, family quality of life satisfaction was relatively high ($M = 3.84$, $SD = .68$). Authors urged researchers to further explore how various facets of religion and spirituality may support family quality of life and how practitioners can encourage these facets when appropriate (Boehm & Carter, 2019b).

In sum, through religious expression, parents and families raising children with disabilities indicated religion can help them accept and make meaning of their child's life (Balasundaram, 2007; Chang & Hsu, 2007). Religious expression can assist parents and family members reframe diagnosis and care routines as a meaningful, if unexpected, journey (Jegatheesan et al., 2010). Further, religion and spirituality can support family quality of life and enjoyment for family members (Boehm & Carter, 2019a; Boehm & Carter, 2019b).

Barriers to Religious Involvement for Families of Youth with IDD

While religious expression was often identified as a supportive factor for parental mental and emotional health raising children and youth with IDD, religious involvement was identified throughout the literature as a negative factor in parental mental and emotional health. Jacober (2010) investigated the experiences of families of adolescents with IDD and their relationship with churches and religious education programs. Prior to the study, the author unsuccessfully attempted to recruit participants by asking more than two dozen religious education leaders and seminary professors if they had any students with disabilities in their youth group or knew of any teenagers with disabilities who attended their church. The typical answer was no; several religious education directors indicated the family had decided the religious education program was not a good fit. The author continued the study by using snowball sampling to identify and recruit parents and guardians from 17 families raising children with diagnoses of social and communication disorders (autism was included in this umbrella) and ID. The author conducted semi structured interviews with participants. Participants described what they perceived as positive experiences with ministries and programs, but the authors noted these were outnumbered by experiences that participants considered to be negative. Families described occurrences they perceived as disheartening, such as being told that a Sunday school teacher would not teach if their child was in the class, being informed the church was unwilling to offer accommodations, or realizing the experience of church had nothing to offer their child. Further, parents relayed the gifts their children could offer to their religious congregation, such as a deep connection with God, benevolent hospitality, and contagious joy, but expressed frustration at the perceived hostility towards including their children.

Similarly, Ault et al. (2013a) investigated the religious involvement of parents and caregivers of individuals with ID or autism for the purpose of discovering barriers to

participation. The authors surveyed 416 parents and caregivers who were current or previous members of a religious congregation. The respondents came from 35 different states and the District of Columbia. Most were mothers (88.1%) who identified as Protestant or Catholic (89.5%) and were raising a child under the age of 18 years (88%) with ID or autism (81.2%). Fewer than 5% of respondents identified as Buddhist, Mormon, or Jewish. In addition, 97.6% attested their faith was important or somewhat important, although their children attended religious services slightly less frequently than their parents. The authors noted the following findings: (a) 55.8% of parents indicated they had kept their child from participating in a religious activity due to absence of supports, (b) 55.3% of parents relayed they were expected to remain with their child to allow participation, (c) 46.2% of parents had never been asked the best way to support their child(ren) in religious activities by anyone in their religious community, and (d) 33% of respondents changed membership to a different religious congregation because of absence of supports. Authors encouraged religious leaders to actively support youth with IDD through accommodations and communication.

Extant literature demonstrates that parents raising children and youth with ID often experience barriers to full participation in religious congregations. These perceived barriers are often due to the absence of supports. When parents perceive hostility or lack of support, they are unable to participate in religious congregations (Ault et al., 2013a; Jacober, 2010).

Supports to Religious Involvement for Families of Youth with IDD

In addition to identifying barriers to religious involvement, several authors pinpointed factors that parents perceived as promoting religious involvement for families of youth with IDD. Griffin et al (2012) surveyed 160 leaders and members of religious congregations on their perception regarding the extent their congregation included people with disabilities. Fourteen

percent of respondents were people with disabilities and 44% of respondents were the family member of a person with a disability. Diagnoses included autism (25%), ID (25%), mental health condition (23%), Down syndrome (18%), and learning disability (18%; participants could indicate more than one diagnosis). Respondents overall believed it was important to fully include people with disabilities (M = 3.53 [out of 4.0], SD = 0.61). Seventy-three percent of leaders indicated their formal preparation included little to no disability-related content. Compared to other groups (i.e., congregation leaders, congregation members), family members rated their congregation lower on: (a) whether their congregation leaders work to include people with disabilities ($F_{[3, 155]} = 2.61$, $p = .053$); (b) whether religious teachings portray people with disabilities positively ($F_{[3, 154]} = 4.50$, $p = .005$); (c) whether congregations have relationships with disability organizations ($F_{[3, 154]} = 5.14$, $p = .002$); and (d) the extent to which roles were available to people with disabilities ($F_{[3, 140]} = 2.73$, $p = .046$). Congregations whose leaders were perceived as more committed to including people with disabilities featured: (a) higher levels of inclusion ($F = 98.37$, $p < .001$); (b) more roles available to people with disabilities ($F = 26.61$, $p < .001$); and (c) a more physically accessible congregation ($F = 15.01$, $p < .001$). Congregations that made decisions by consensus (i.e., versus hierarchical structures) were more welcoming and inclusive ($F_{[5, 147]} = 3.23$, $p = .009$) and offered more roles in which people with disabilities contributed ($F_{[5, 137]} = 3.05$, $p = .012$). Authors found no differences based on the number of congregants with disabilities, urbanicity of the congregation (i.e., rural, suburban, urban), or the affiliation or denomination of the congregation. Authors concluded that (a) efforts to promote inclusion of people with disabilities should focus on building capacity in leaders; and (b) further research is needed to examine if study findings are transferred to cultural groups and denominations underrepresented in the study (Griffin et al., 2012).

Richardson and Stoneman (2015) examined the importance of resilience in families raising children with disabilities who seek religious congregation membership. They found that familial resilience was a helpful framework in understanding the journey to membership for families raising children with disabilities in a Christian religious congregation. Parents described several experiences with both positive and negative perceptions. The authors concluded that families who displayed patterns of resilience (e.g., advocating for their children, being willing to communicate with leaders, engaging in active problem solving, taking on a leadership role) were more likely to report positive experiences and familial well-being. Results also showed involvement in the religious congregation can have a negative effect on familial well-being when families do not display patterns of resilience, or when their persistence is met with a negative response from the religious congregation. Suggestions for future research included exploring perceptions of individuals with disabilities and other family members not included in the study (i.e., not mothers). Further, authors encouraged religious congregations to learn how to support families raising youth with IDD in the congregation.

Further, Carter, Boehm, et al. (2016) explored congregation-provided supports perceived as most helpful by parents raising children with ID and autism. The authors also examined the availability of the supports, the responsiveness of the religious congregation to individuals with ID or autism, and which factors (e.g., parent support groups, respite care, family advocates) were associated with this responsiveness. The authors surveyed 433 parents or caregivers of adolescents and young adults with ID or autism. Most participants (85%) were mothers (biological, step-, or adoptive); and the parents identified themselves with 35 different religious traditions, mostly Protestant Christian or Roman Catholic. Over half of the respondents specified they attended worship services at least once a week. The survey listed 14 potential supports (e.g.,

respite care, support groups, physical accessibility, special worship services, and family advocates) that religious congregations could provide. Most parents (range = 67%–96%) reported their religious congregation did not facilitate each individual support. Almost half (44.9%) of the respondents said none of the supports were available in their religious congregation. Additionally, parental perceptions of overall support were significantly positively correlated with the availability of these individual supports. Parents reported the most helpful supports were support groups for parents (M = 3.04), congregation-wide disability awareness efforts (M = 3.01), resource centers for families with disabilities (M = 2.99), and an advocate to work specifically with families (M = 2.95). However, the latter two were among the least available supports (available in 6.3% and 4.4% of participants' congregations, respectively). The most common available supports were (a) spiritual counseling from a religious congregation leader (found in 32.8% of participants' religious congregations), and (b) physically accessible facilities (22.8%). The size of religious congregation membership was positively correlated with the number of supports offered. Authors emphasized the future need to study the perceptions of religious leaders (e.g., clergy) on (a) the support needs of families of individuals with IDD, (b) the capacity of congregations to support individuals with IDD, and (c) theological reasons for doing so (Carter, Boehm, et al., 2016).

Findings from existing literature provided initial recommendations for religious congregations to employ when determining the supports and accommodations they currently or could provide. Namely, religious congregations should seek to provide support groups, advocacy, and resources for parents raising children with ID (Ault et al., 2013). Further, literature suggested that religious congregations may benefit from training in awareness of and strategies for supporting individuals with ID in religious congregation.

Perceptions of Religious Congregation Leaders

While studies examining perceptions of youth and young adults with IDD and their parents documented barriers to support and participation, few studies examined the perception of religious congregation leaders on these barriers. Stewart-Ginsburg et al. (2020) investigated the experience, knowledge, and attitudes of religious congregation leaders toward supporting individuals with disabilities. Three hundred six clergy, staff members, and volunteers who served in religious education roles in religious congregations completed an online survey. The majority of participants were clergy members (62.1%) who completed a seminary training program (56%) and identified with a Christian faith tradition (65%). Participants demonstrated high levels of experience and awareness supporting individuals with disabilities. In regard to supporting individuals with disabilities, most participants did not (a) receive training (68.2%) and (b) believe their training adequately prepared them to support individuals with disabilities (86.4%). A majority of participants perceived they had competencies necessary to support an individual with a learning disability (59.6%) and a physical disability (54.1%). Approximately half of participants believed they had the capacity to support an individual with autism (50.3%) or ID (46.2%). Few participants believed they could support an individual with multiple disabilities (34.3%). Combined participant responses to items that measured experience and attitudes to compute a participant experience and confidence sum score. Experience supporting individuals with disabilities was positively correlated with perceived confidence ($r = .510$, $p < .01$). The authors utilized a discriminant function analysis and determined group membership in the "had received training" group could be predicted by experience and confidence sum scores (Wilk's $\Lambda = .913$, $\chi^2 = .25.852$, $p = <.001$). Participants who had higher confidence and experience sum scores were more likely to be classified as having received training. Authors suggested the

barrier to competent religious congregation leaders was in explicit instruction and training deficits rather than attitudinal barriers (Stewart-Ginsburg et al., 2020).

Stewart-Ginsburg et al. (2021) continued this inquiry with three semi structured focus groups exploring the knowledge and experience of 13 religious leaders supporting children and youth with disabilities. Participants served as clergy members (n = 7) and religious education directors (n = 5). Leaders shared an equal number of positive and negative experiences supporting children and youth with disabilities. Familial perceptions, parental exhaustion, insufficient parent communication, and staunch rituals were portrayed as perceived barriers to participation for children and youth with disabilities, while the presence of advocates, buddies, and persons with disabilities were perceived supports to participation. Leaders expressed hesitation knowing and enacting strategies to support children and youth with disabilities and did not believe they received adequate training in this (Stewart-Ginsburg et al., 2021).

Summary

Religious expression and involvement, while ancient notions, can be important factors for individuals providing opportunities for rituals and prosocial connection. Persons who identify as religious often engage in personal devotions (e.g., prayer) and community rituals (e.g., worship services). This sentiment holds true for youth and young adults with IDD in these youth and young adults can hold and articulate religious belief (Carter & Boehm, 2019; Liu et al., 2014). Yet, religious involvement for youth with IDD remains statistically disproportionate as children and youth with ID are more likely than peers without chronic health conditions to never attend religious activities (Whitehead, 2018). Religious congregations often do not provide support in ritual participation and prosocial development for these youth with IDD (Liu et al., 2014). This can affect religious involvement for the family of an individual with IDD who perceive the

religious congregation to be unsupportive (Ault et al., 2013a; Jacober, 2010). Parents raising youth with IDD identified religious expression as a positive factor in their mental and emotional health, but religious involvement was often a stressful activity (Ault et al., 2013a). Additionally, studied found parents raising youth with IDD perceived the presence of resources and awareness of disability as important factors in their perceived level of support from the religious congregation (Ault et al., 2013a; Carter, Boehm, et al., 2016). However, research is needed to investigate strategies that provide religious congregation leaders with methods for promoting religious participation for individuals with IDD and their families. Training for religious congregation leaders may be one such method to support religious expression and involvement for youth and young adults with IDD and their families in religious congregations and, thus, increase overall support for youth with disabilities in religious congregations and community organizations.

2.4 Professional Development for Community and Religious Congregation Leaders

Personnel preparation efforts should apply to the "full range" of professionals who support individuals with disabilities (Blalock et al., 2003, p. 2). Because religious congregation leaders do not receive adequate training in supporting individuals with disabilities (Annandale & Carter, 2014; Stewart-Ginsburg et al., 2020), training may be required to develop capacity. Annandale and Carter (2014) explored the extent seminaries (i.e., theological training programs) prepare religious congregation leaders to support individuals with disabilities. The survey included 118 administrators and faculty members from theological institutions in the United States and Canada. For the majority of respondents, they found (a) seminaries did not often offer opportunities for students to interact with individuals with disabilities or disability-related topics, (b) topics related to disability and supporting individuals with disabilities were rarely addressed

in the curriculum, and (c) faculty members and administrators believed their institution did not adequately prepare seminarians to support individuals with disabilities. Authors concluded that theological training institutions should generate intentional comprehensive methods for religious leaders, such as training on strategies for supporting persons with IDD.

Training Frameworks for Religious Congregation Leaders

Several researchers proposed frameworks and strategies for supporting individuals with disabilities in religious congregations (e.g., Collins et al., 2001; Goldstein & Ault, 2015; Newman, 2011). These strategies included accommodations religious congregations could provide, such as an instructional aide in religious education classes or worship visual schedule, and modifications religious congregations could offer persons with disabilities, such as revised requirements for rituals (e.g., communion, *b'nei mitzvah* ceremony; Collins et al., 2001; Goldstein & Ault, 2015; Newman, 2011). However, these frameworks did not include evidence of effectiveness. Therefore, there is a need to evaluate effective training opportunities for religious leaders to learn and implement strategies to support youth and young adults with disabilities in religious congregations.

While seminaries do not comprehensively prepare pre-service religious congregation leaders to support persons with disabilities (Annandale & Carter, 2014), Kleinert et al. (2010) aimed to increase the experience of seminarians in supporting individuals with disabilities. Authors created a family mentorship program that paired 25 seminary students at a nearby seminary with a family of a child or youth with a disability as part of a required practicum experience for a pastoral care class (e.g., a class that prepared students to provide spiritual and emotional support to congregation members). Disability diagnoses comprised autism, Down syndrome, and cerebral palsy. Seminarians were trained in expectations, disability etiquette, and

person-first language before beginning their visits. All student participants were upper-level students (i.e., in the third or fourth year of a four-year program) and ranged in age from 24 to 60 years. Each seminary student completed three unstructured visits with the family in a variety of settings (e.g., dinner at the family's house, at a park) and reflected on the experience. After the experience, participants completed a retrospective pretest. Prior to the training more than three quarters of the students perceived their knowledge as *not at all, minimal,* or *somewhat* on (a) services available to persons with disabilities, (b) potential treatment by the public, (c) impact on a family, and (d) the unique needs and challenges a person with a disability experiences. The largest perceived change following the externship experience was an increase in awareness of the unique needs and challenges faced by persons with a disability and their families in relation to a religious congregation (e.g., transportation, participation in religious rituals).

Next, Baggerman et al. (2015) investigated the effects of teacher coaching on the use of evidence-based teaching behaviors by a volunteer religious congregation teacher educating a child with extensive support needs in an inclusive classroom. They utilized a multiple baseline across behaviors design to evaluate a coaching intervention that used the Tell-Show-Try-Apply model (TSTA; Browder et al., 2012) to teach three specific behaviors, including opportunities to respond (OTR), behavior-specific praise (BSP), and opportunities to participate (OTP). The participating teacher was a 47-year-old female who worked as a dental hygienist, taught a class at the church for 33 years, and had no prior experience teaching children with disabilities. Hope, a 5-year-old student with Down syndrome, was in her class. The authors observed and recorded the frequency of the strategy used during 15 min sessions in the teacher's weekly hour-long Sunday School class. For the intervention, the first author conducted a 25 min training session that occurred before the class and addressed one of the three targeted behaviors. No student

outcomes were measured. Results showed the teacher provided no OTR or OTP and one BSP during baseline sessions. Visual analysis indicated the coaching intervention was effective in increasing the level and trend of OTR (M = 4.1 occurrences per session) and BSP (M = 5.2 occurrences per session), and effective in increasing the level of OTP (M = 3 occurrences per session), with 100% nonoverlapping data across all three behaviors. The teacher appraised the intervention as valuable and helpful. Authors suggested the TSTA model could be a viable method for training religious congregation leaders to support children and youth with disabilities using three strategies (i.e., OTR, OTP, BSP).

Research-Supported Practices in Online Professional Development (PD)

Limited research exists in effective practices for online asynchronous PD opportunities (Borup & Evmenova, 2019). This may be due to institutional reliance on face-to-face opportunities (Meyer & Merrell, 2014). However, emergent evidence supports the use of several strategies for online engagement of adult, in-service learners. First, online asynchronous PD should be structured as either (a) a cohort-based model that prioritizes interaction among learners or (b) a flexible model that prioritizes independent learning and autonomy (Brooks, 2010; Reilly et al., 2012). Online asynchronous PD should maintain a quick pace of learning that mirrors the pace of college courses (Borup & Evmenova, 2019). Meaningful PD opportunities include content participants find useful, relevant, and based on professional needs (Walters et al., 2017). Needs assessments can be useful in determining content prior to development (Ginzburg et al., 2010). After the course ends, participants should have continued access to course materials so they can review and practice information (Borup & Evmenova, 2019). In addition, researchers identified eight standards of online course design associated with increased perceived student engagement and interest for in-service practitioners (Diehl, 2016; Diehl, 2018; Hollowell, 2017).

The eight standards, entitled the QualityMatters framework assert the need to design online courses that provide: (a) a course overview and introduction, (b) posted learning objectives, (c) relevant assessments, (d) instructional materials, (e) learning activities and interaction, (f) course technology requirements, (g) learner support, and (h) maximized accessibility and usability (QualityMatters, 2018). The proposed intervention implements these standards.

Professional Development in Predictors of Post-School Success

Given limited research on interventions to support youth and young adults with IDD in religious congregations, research is needed to determine effective methods for training religious congregation leaders to support youth with disabilities. One potential topic to train religious congregation leaders are the evidence-based secondary transition Predictors of Post-School Success. Test, Mazzotti, et al. (2009) reviewed the literature to identify in-school predictors of improved post-school outcomes for youth with disabilities. The authors identified secondary transition high-quality correlational studies published between January 1984 and March 2009 that investigated relationships between predictor and outcome variables. Twenty-two articles with a total of 26,480 participants matched their inclusion and quality indicator criteria. Authors analyzed the articles for effect size. Results identified 16 evidence-based predictors of improved post-school outcomes associated with education, employment, and independent living outcomes. Across 10 articles, inclusion in general education (e.g., youth with disabilities participating in the general curriculum) was identified as a predictor of education (r = .27–.74), employment (r = .06–.37), and independent living (r = .06–.48) with a *moderate* level of evidence and small to large effect sizes. Authors encouraged state and local education agencies to offer student opportunities for inclusion (Test, Mazzotti, et al., 2009).

To expand the conceptualization of these predictors, Rowe et al. (2015) utilized a Delphi consensus-building method and operationally defined each of the 16 predictors. Twenty-two experts in the field (i.e., authors, researchers, experienced practitioners) participated in a three-round nominal group technique process and created a definition and essential characteristics for each predictor. For example, community experiences were defined as "activities occurring outside the school setting, supported with in-class instruction, where students apply academic, social, and/or general work behaviors and skills" (p. 120). The definitions and essential characteristics provide criteria and guidelines program administrators can utilize in ensuring system-level implementation of the predictors. Further, the definitions and essential characteristics allow broad implementation designed to be tailored to unique agency needs (Rowe et al., 2015). Researchers distilled and built consensus on one definition and eight characteristics of the predictor Inclusion in General Education that practitioners deemed essential for implementation, defining Inclusion in General Education as a process that requires students with disabilities to have access to general education curriculum and be engaged in regular education classes with peers without disabilities" (Rowe et al., 2015, p. 120).

Next, Mazzotti et al. (2016) expanded and updated the Predictors of Post-School Success by reviewing analyses of the NLTS2 that included a sample of 21,093 participants across waves. In addition to strengthening findings by Test, Mazzotti, et al. (2009), authors identified four additional predictors for a total of 20 predictors: (a) goal setting, (b) youth autonomy, (c) travel skills, and (d) parent expectations. In examining the literature for Inclusion in General Education, they found three articles linking Inclusion in General Education to employment outcomes and one article linking Inclusion in General Education to education outcomes (r = .034 to .582). Additionally, Mazzotti et al. (2021) reviewed high quality correlational studies published

between April 2009 and January 2019. Twenty-two articles met their inclusion criteria; they analyzed effect sizes (r = 0.02–3.74) to determine the level of evidence (i.e., *promising, research-based, evidence-based*) for each predictor. Their review added evidence to 14 existing predictors and identified three new predictors: (a) psychological empowerment, (b) self-realization, and (c) technology skills. They identified three studies with effects in postsecondary education and one article with effects in employment (r = -.29–.42), allowing authors to classify Inclusion in General Education as a Research-Based Predictor (Mazzotti et al., 2021).

Next, Mazzotti et al. (2021) updated the evidence base for the 20 previously-identified predictors and identified three new predictors. They reviewed high-quality correlational literature published between April 2009 and January 2019 demonstrating relationships between predictor variables and education, employment, and independent living outcomes for secondary youth with disabilities. Twenty-two articles met their inclusion criteria demonstrating effect sizes ranging from 0.02 to 3.74 (M = 0.34). Authors identified additional evidence for 14 predictors and classified three new predictors: psychological empowerment, self-realization, and technology skills (Mazzotti et al., 2021). Evidence identified in the review allowed authors to classify Inclusion in General Education as a research-based predictor of post-school education, employment, and independent living. Authors found no new evidence for Community Experiences as a predictor of post-school success (Mazzotti et al., 2021).

Despite the empirical validation of these 20 predictors, little research has been conducted to explore the perceived effects of implementing the Predictors of Post-School Success in community experiences external to school systems (e.g., religious congregations). Understanding the perception of service providers is important given the importance of related service providers and agencies in community transition planning (Blalock, 1996). Mazzotti et al. (2013) deemed it

beneficial for practitioners to be able to identify practices and predictors that produce favorable outcomes for students in specific settings.

To this effort, I conducted two focus groups with religious congregation leaders to determine the relevance of the Predictors of Post-School Success in religious congregations. Eight participants served as clergy members (n = 3) and religious education directors for adolescents (n = 5) at six Christian churches in a large, urban area. I used a Nominal Group Technique (Moore, 1994) to draft a consensus-building procedure used to gather perceptions of religious congregation leaders on the (a) perceived relevance, (b) perceived importance, and (c) perceived level and manner of implementation of the 20 Predictors of Post-School Success identified by Test, Mazzotti, et al. (2009) and Mazzotti et al. (2016) in religious congregations. Mazzotti et al. (2021) was in preparation at the time focus groups were held.

Participants across both groups appraised the following Predictors as relevant: (a) Community Experiences, (b) Inclusion in General Education, (c) Self-Advocacy/Self-Determination, (d) Self-Care/Independent Living, (e) Social Skills, (f) Student Support, and (g) Youth Autonomy/Decision-Making. Additionally, participants in the first focus group appraised Goal-Setting, Interagency Collaboration, and Paid Employment/Work Experience as relevant. Likewise, participants in the second focus group also appraised Career Awareness, Parental Involvement, and Travel Skills as relevant. Last, participants voted on three Predictors they believed to be most relevant to their work. The following Predictors received votes: (a) Community Experiences (n = 7), (b) Social Skills (n = 6), (c) Inclusion in General Education (n = 5), (d) Parental Involvement (n = 3), (e) Youth Autonomy/Decision-Making (n = 2), (f) Parent Expectations (n = 1), and (g) Student Support (n = 1).

After reading definitions and characteristics, participants qualitatively expressed the most interest in receiving training in Inclusion in General Education. I selected Inclusion in General Education for the intervention because it contains the framework to address training areas for religious congregation leaders identified in previous studies of religious congregation leaders. Participants in Stewart-Ginsburg et al. (2020) expressed preference for training in strategies to include and engage children and youth with disabilities. Participants in Patka and McDonald (2015) expressed hesitation over how to help Catholics with IDD participate in sacraments. Participants in Francis and Jones (2015) shared unease over communicating with and about persons with disabilities. Inclusion in General Education addresses these three strands of training. Rowe et al. (2015) defined Inclusion in General Education as a process where youth with disabilities "have access to general education curriculum and be engaged in regular education classes with peers without disabilities" (p. 120). This definition can be contextualized (i.e., "general education" becomes "general congregation") without changing the meaning of the definition. Further, Inclusion in General Education contains essential characteristics than can be implemented within congregations (e.g., "Use diverse instructional strategies to meet the learning needs of all students including UDL [universal design for learning], technology, and linking instruction to student interests" (Rowe et al., 2015, p. 120).

The Inclusion in General Education framework asserts Universal Design for Learning (UDL) as one way to meet the needs of all students (Rowe et al., 2015). UDL is a set of criteria for curriculum development that provide equal opportunities to learn for students with and without disabilities (CAST, 2018). To implement UDL, instructors must offer multiple means of representation, action/expression, and engagement. These principles have shown effective for increased engagement in classrooms for youth and young adults with and without disabilities

(e.g., Alper & Raharinirina, 2006; Boon et al., 2006; Higgins et al., 1996; Luiselli et al., 2002). However, UDL training modules cited in the literature and/or found through national technical assistance centers at the time of this study are contextualized for classroom teachers and school administrators (e.g., IRIS modules, Vanderbilt Peabody Center, 2019) and not for community or religious congregations. Because UDL is designed to be implemented across contexts (e.g., school, community agency), religious leaders may find training in this area beneficial to supporting youth and young adults with IDD.

Summary

Few studies exist on preparing religious congregation leaders to support youth and young adults with disabilities. Two methods with initial evidence are (a) a family mentorship program for seminarians (Kleinert et al., 2010) and a coaching package for religious education teachers (Baggerman et al., 2015). While these methods demonstrated initial evidence to increase the perceived capacity of religious congregation leaders, they do not address the existing need for a systematic way to train religious leaders to support youth with disabilities (Annandale & Carter, 2014). First, both methods require time-intensive support from trainers (e.g., conducting observations, providing feedback, organizing family programs). Second, both methods do not offer a strategy or framework that can be implemented in a context-specific manner, which is an area that religious leaders identified as an essential component of training (Stewart-Ginsburg et al., 2021). Over the past 11 years, researchers identified 23 Predictors of Post-School Success (Mazzotti et al., 2016, 2021; Test, Mazzotti, et al., 2009). These predictors were defined and operationalized in such a way that can be implemented in a context-specific manner across agencies (Rowe et al., 2015). Inclusion in General Education was identified a research-based predictor of post-school education, employment, and independent living (effect sizes ranged

from small to large; Mazzotti et al., 2021) with an operationalized definition and eight essential characteristics (Rowe et al., 2015). However, researchers have paid little empirical attention to investigating the effects of implementing these predictors (e.g., Inclusion in General Education) to increase support for youth with disabilities within religious congregations. One way to increase support for youth in religious congregations is to train religious leaders to implement one or more Predictors of Post-School Success in religious congregations. With a strong research base, characteristics of Inclusion in General Education as a predictor of post-school success may provide a framework for religious leaders to increase support for youth and young adults with disabilities. This framework includes providing access to inclusive community settings and ensuring youth are engaged in these settings (Rowe et al., 2015), which may be a viable starting point for congregations.

CHAPTER 3: METHOD

In this study, I employed a concurrent mixed-method design using qualitative participant responses throughout the study to enhance results and findings of an experimental randomized control trial design (Bal & Trainor, 2016; Boruch, 1997; Gersten et al., 2005). Pairing a group experimental and qualitative design enabled researchers to capture the participant's view of an intervention and strengthen interpretation of findings and salience to participants (Bal & Trainor, 2016; Trainor, 2011). I evaluated the effects of ROLLING PD on religious congregation leaders' knowledge and confidence implementing Inclusive Language and Inclusive Learning (Rowe et al., 2015). The proposed methods addressed three research questions: (a) What are the effects of PD on religious congregation leaders' knowledge and confidence implementing Inclusive Language and Inclusive Learning? (b) What opportunities, barriers, and implementation drivers do religious leaders identify for supporting youth and young adults with IDD in religious congregations as a result of this training? and (c) How do religious congregation leaders perceive this training?

3.1 Participants

I recruited 71 leaders to participate in the study. Eleven leaders agreed to participate in the study but did not complete pretest tasks, resulting in 60 participants. Participant recruitment methods and characteristics are discussed in subsequent sections. To be eligible for participation, leaders had to be (a) members of the clergy currently serving a religious congregation or (b) staff members (e.g., religious education director) serving a religious congregation whose professional responsibilities included or consisted of planning activities and/or promoting religious engagement for transition-aged youth (e.g., 14 to 21 years). In addition, prior to the study, participants must not have received formal training in supporting individuals with disabilities

(i.e., a major or minor part of a degree program conferred by an accredited institution in the areas of special education, inclusive education, disability services, or rehabilitation).

3.2 Setting

The setting for the intervention was an online training course hosted on the Instructure Canvas (Canvas) learning management system (LMS). Canvas is accessed through any internet-capable device with a modern browser (e.g., desktop computer, tablet, smartphone) and uses a responsive design to deliver an optimal user experience. Canvas complies with Web Content Accessibility Guidelines 2.0 accessibility standards and is available in 45+ languages. Only the research team and Canvas team members had access to direct participant data; access conformed to appropriate data management protocols. Participants created an individual login username and password which they used to access the lessons on Canvas. Participants were provided with training on how to navigate Canvas and access the intervention immediately upon logging into the course for the first time. Participants accessed online videos (i.e., screencasts) and course materials using Canvas. All data collection took place through Canvas (i.e., knowledge probes, confidence probes, implementation probes, social validity questionnaire).

3.3 Materials

I created six lessons to systematically teach two essential characteristics of one predictor of post-school success (i.e., Inclusion in General Education). The six content lessons taught aspects of two Inclusion essential characteristics. These essential characteristics included (a) “Provide professional development for secondary personnel to ensure personnel are qualified to use UDL [Universal Design for Learning] and evidence-based instructional strategies,” (i.e., stylized as Inclusive Language); and (b) “Develop a receptive atmosphere for including students with disabilities in general education by educating administrators, teachers, other staff, and

students about person-first language and disability rights" (i.e., stylized as Inclusive Learning; Rowe et al., 2015, p. 120).

The training was organized into two units (i.e., Unit 1: Inclusive Language, Unit 2: Inclusive Learning) with three lessons per unit. The information was presented primarily through interactive videos that ranged from 5 to 15 min. I created videos using a Nikon D5200 digital single-lens reflex camera, Tokina AT-X 11-20mm f/2.8 Pro DX lens, and Movo VXR10 cardioid microphone. I edited videos using Apple iMovie on a Macintosh laptop and used graphics from Microsoft PowerPoint to provide content-specific visual cues. Videos were uploaded to EdPuzzle, close-captioned, and embedded into Canvas LMS. As participants watched videos, they answered multiple choice and short-response questions at a rate of approximately one question per 2 min of video content. Answers to these questions were not recorded and were solely for the purpose of learner engagement (QualityMatters, 2018). See Appendix A for lesson examples of the online PD. All measures were completed through Canvas (i.e., knowledge probes, confidence probes, implementation probes, social validity questionnaire).

3.4 Principal Investigator and Outside Rater

I was the principal investigator and experimenter. Prior to the doctoral program, I served as a general education inclusion teacher at a public elementary school and a family resource coordinator at a nonprofit early childhood partnership operated by a religious congregation. As primary experimenter, I was responsible for (a) obtaining IRB approval, (b) recruiting participants, (c) developing the ROLLING PD, (d) facilitating administration across all study phases, and (e) training an outside observer to collect interrater reliability data. The outside observer was a first-year doctoral student who previously served as a secondary special education teacher. I trained the outside observer to collect interrater reliability on (a) the primary

and secondary DV (i.e., knowledge, confidence) for at least 40% of data across all phases and (b) procedural fidelity across all phases.

3.5 Design

I implemented a waitlist randomized control trial design (Boruch, 1997; Gersten et al., 2005). Participants were randomly assigned to one of two conditions: a control or treatment group. Participants in the control group completed all dependent variable measures (i.e., learning check, confidence check, dimensions of belonging rating), but did not have access to or complete the ROLLING PD. Participants in the treatment group completed the ROLLING PD and completed dependent variable measures prior to and immediately following intervention. The control group was given access to the ROLLING PD after data collection stopped.

3.6 Quantitative Data Collection and Analysis

This study examined the effects of the Religious Organization Leaders Learning Inclusive Guidelines (ROLLING) PD on two dependent variables (DV), including (a) participant content knowledge of two Inclusion essential characteristics (i.e., Inclusive Language, Inclusive Learning); and (b) participant confidence implementing two Inclusion essential characteristics (i.e., Inclusive Language, Inclusive Learning). Further, I measured change in Dimensions of Belonging as a distal variable (Carter, Biggs, et al., 2016). I used two quantitative data analysis approaches to address each of the research questions. These methods comprised analysis of variance (RQ1) and descriptive statistics (RQ2, RQ3).

Participant Knowledge

The primary DV was participant knowledge of two Inclusion essential characteristics (i.e., Inclusive Language, Inclusive Learning). Participant knowledge was defined as content knowledge of Inclusive Language and Inclusive Learning taught through the ROLLING PD.

This DV was measured by the number of points earned on an 11-question researcher-developed instrument measuring content knowledge taught through ROLLING PD lessons (i.e., 15 possible points). Participants in the treatment group completed this measure prior to and following the ROLLING PD intervention. The 11 questions of the measure were randomly chosen from an 18-question bank (see Appendix B for this measure). The measure assessed content knowledge from each of the six lessons and comprised multiple choice, matching, and fill-in-the-blank questions. Participants earned one point for each correct response. Eight questions required participants to select one choice (i.e., one possible point per question) and four questions required participants to select two choices (i.e., two possible points per question) for a total possible score of 15 points. The probe required participants to (a) identify two examples of person-first language, identity first-language, or appropriate language; (b) select two examples of a modification or accommodation; (c) complete one step of the three-step process of teaching social skills; (d) select the type of multiple means of representation an example described (i.e., perception, language, understanding); (e) select the type of multiple means of action and expression an example described (i.e., physical action, expression, executive function); and (f) select the type of multiple means of engagement an example describes (i.e., posting expectations, promoting community, planning examples). Participants completed this measure within the Canvas Quizzes engine. Measures were automatically scored in Canvas LMS after participants completed them. See Appendix B for the primary DV measure.

Participant Confidence

Confidence is a relevant construct to measure for religious leaders. First, training activities that increase confidence in a set of skills or behaviors promotes goal attainment and behavior change (Kosmala-Anderson, 2010; Williams et al., 2004). Religious congregation

leaders often report a lack of confidence and agency supporting individuals with disabilities (Francis & Jones, 2015; Stewart-Ginsburg et al., 2020). Therefore, the secondary DV was participant confidence implementing two Inclusion essential characteristics (i.e., Inclusive Language, Inclusive Learning). This was measured on a self-report questionnaire completed by participants after each lesson. Participants completed an adapted version of the Perceived Confidence Scale (PCS; Williams & Deci, 1996). The PCS is an instrument that measures the relevant behavior or domain being studied and had high internal reliability ($\alpha > 0.80$; Center for Self-Determination, 2020; Williams & Deci, 1996; Williams et al., 2004). I adapted the PCS for the present study by revising question foci to describe religious congregations (e.g., "I am able to meet the challenge of controlling my diabetes" was revised to, "I feel able to meet the challenge of supporting individuals with disabilities in religious congregations"). Participants rated their agreement with four statements on a 7-point Likert-type scale from 1 (*Not at all true*) to 7 (*Very true*) for a total of 28 points. This raw score was divided by the total number of items (i.e., 4 items) to compute an average score (i.e., a possible score of 7 points). Participants rated their agreement with four statements: (a) *I feel confident in my ability to implement inclusive language in a religious congregation,* (b) *I feel confident in my ability to implement inclusive learning in a religious congregation*, (c) *I feel confident in my ability to support individuals with disabilities in religious congregations,* and (d) *I feel able to meet the challenge of supporting individuals with disabilities in religious congregations*. See Appendix C for the Participant Confidence questionnaire. Participants completed this probe measure with the knowledge measure within the Canvas Quizzes engine prior to and following intervention.

Dimensions of Belonging

While the Predictors of Post-School Success (Mazzotti et al., 2016, 2021; Test, Mazzotti, et al., 2009) were associated with IDIEA-related outcomes (i.e., postschool education, employment, independent living), youth and young adults with disabilities and their families may value other characteristics as markers of positive outcomes in religious congregations (e.g., friendship; Boehm & Carter, 2019; Carter et al., 2011; Liu et al., 2014). Carter, Biggs, et al. (2016) identified 10 characteristics associated with congregational satisfaction by parents raising youth with IDD, describing these as Dimensions of Belonging within the religious congregation. Participants completed the Dimensions of Belonging Rating Scale (adapted from Carter, Biggs, et al., 2016) prior to and following completion of the ROLLING PD. Leaders rated their agreement on 10 statements reflecting each of the 10 Dimensions of Belonging using a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*): *At my congregation, people with disabilities are* (a) *present,* (b) *noticed,* (c) *welcomed,* (d) *cared for,* (e) *supported,* (f) *accepted,* (g) *known,* (h) *befriended,* (i) *needed, and* (j) *loved* (see Appendix D for this measure). During the post-intervention probe, participants completed an open-ended question that asked them to, "explain any changes made in the way you rated your congregation after completing the ROLLING PD lessons." Participants completed this measure within the Canvas Quizzes engine.

Quantitative Data Analysis

I used Analysis of Covariance (ANCOVA) to answer both components of RQ1 (i.e., What are the effects of ROLLING PD on religious congregation leaders' knowledge and confidence implementing Inclusive Language and Inclusive Learning?). I used two ANCOVAs to make inferences about group means that involve factors within and between subjects irrespective of the number of factors involved (Huck, 2012). Particularly, the ANCOVA allowed me to ascertain whether population means for each dependent variable (i.e., knowledge,

confidence) were equal across factors (i.e., ROLLING PD), adjusting for differences in covariates (Huck, 2012). The ANCOVA is most appropriate for determining the differences between effects rather than amount of improvement (Wright, 2006). I used a block randomization technique to ensure group equivalence (Kang et al., 2008) and meet the assumptions necessary for an ANCOVA (Huck, 2012). I conducted a one-way ANOVA to test for group equivalency of the pretest scores for participants in each condition. A nonsignificant *p*-value indicated group equivalency. Thus, I established the following hypotheses:

H0: $\mu 1 = \mu 2$

H1: $\mu 1 \neq \mu 2$

The study met the assumptions required for running an ANOVA, including (a) continuous dependent variables (i.e., scores on the Knowledge, Confidence, Dimensions of Belonging rating); (b) categorical independent variable; (c) independent groups; (d) random sampling; (f) approximate normal distribution of the dependent variable for each group; (g) homogeneity of variance; and (h) no expected outliers (Huck, 2012). In addition, the study met the assumption of a linear relationship between pretest and posttest (Huck, 2012). I used the pretest scores as a covariate and ran ANCOVA for each of the administered assessments (i.e., Knowledge, Confidence). I established the null hypothesis as no difference between the means of various conditions (**H0: $\mu 1 = \mu 2$**) and the alternative hypothesis as a difference between at least two of the means (**H1: $\mu 1 \neq \mu 2$**). The results of the ANCOVA offered information about the interaction and main effect. Prior to data collection, I set the alpha level at $p < .05$ and determined there was strong evidence to reject the null hypothesis when $p < .05$ was achieved. I conducted a one-way ANOVA on differences across group means for demographic characteristics of participants (i.e., cultural background, proximity to a person with IDD,

experience supporting youth/young adults [with/without disabilities], preparation, urbanicity, role).

Descriptive Analysis

I used descriptive analyses to answer RQ3 (i.e., How do religious congregation leaders perceive this training?). Descriptive statistics (i.e., frequency, mean, standard deviation) of participant responses to social validity questionnaire are reported in Chapter 4.

3.7 Social Validity

Social validity measures on procedures, goals, and outcomes were gathered from participants (Schwartz & Baer, 1991). After finishing the ROLLING PD lessons, participants in the treatment group completed a social validity questionnaire. The questionnaire was adapted from the Primary Intervention Rating Scale (PIRS; Lane et al., 2009) which reported high internal consistency (α = .93). I adapted the instrument by keeping question stems intact and replacing the name of the program specified in the instrument (i.e., intervention) with the name of the PD (i.e., ROLLING). First, participants ranked their agreement with 10 statements using a 6-point Likert-type scale (i.e., 1 = *strongly disagree*; 6 = *strongly agree*). Next, participants responded to five open-ended questions, which measured (a) most and least beneficial components of the ROLLING PD, (b) components that increase or do not increase capacity to support individuals with disabilities, (c) suggested changes, (d) future training topics, and (e) any additional information participants wished to share. See Appendix E for the social validity questionnaire.

3.8 Qualitative Data Collection and Analysis

While quantitative methods allowed me to measure participant performance and appraisal of the intervention, qualitative methods provide more nuanced and thematic understanding,

including how participants perceive goals, outcomes, and procedures of the intervention (Trainor & Graue, 2014). Therefore, I analyzed qualitative data provided in participant implementation reflections analysis to address RQ2 (i.e., What opportunities, barriers, and implementation drivers do religious congregation leaders identify for supporting youth and young adults with IDD in religious congregations as a result of this training?).

Implementation of Inclusive Language and Inclusive Learning Characteristics

The first stage in implementing a practice is exploration and adoption (Bertram et al., 2014). Training programs should embed opportunities for participants to consider how they would implement specified practice(s) and barriers that might prevent them from implementing the practice(s) (Bertram et al., 2014). Training programs should also embed opportunities for participants to consider what factors are needed to implement ideas or remove barriers to implementing practice(s), often referred to as implementation drivers (Bertram et al., 2014). Implementation drivers improve organizational capacity in three areas: (a) competency (i.e., improvements to the competence and confidence of practitioners); (b) organization (i.e., factors that create a more welcoming environment; and (c) leadership (i.e., responsible persons that determine priorities and implementation; Bertram et al., 2014).

I used this framework to measure implementation of two Inclusion essential characteristics (i.e., Inclusive Language, Inclusive Learning) through thematic analysis of written participant responses to open-ended questions. After completing each unit of lessons (i.e., Inclusive Language, Inclusive Learning), participants in the treatment group were asked to reflect on ways they might implement aspects of the two essential characteristics. Participants provided written qualitative responses to three questions in the qualitative implementation questionnaire via the Canvas Quizzes engine: (a) *What are some ways you could implement what*

you learned in this unit, (b) *What barriers might stop you from implementing these ideas?* and (c) *What could help you implement these ideas or remove the barriers you might face to implementing these ideas?*

Qualitative Analysis

Researchers analyzed participant responses from the implementation questionnaires. Researchers followed quality indicators for qualitative research (Brantlinger et al., 2005; Trainor & Graue, 2014) by (a) triangulating subcodes with members of the dissertation committee; (b) initiating member checking with participants; (c) facilitating a teamed approach to qualitative analysis; and (d) reporting disconfirming evidence. I and fellow researchers used an inductive structural coding method (Saldaña, 2013) to identify phenomena within the research questions. Researchers coded responses using the following structural codes within an implementation framework (Bertram et al., 2014), including (a) opportunities (i.e., programs, events, or other ways identified by participants to implement Inclusive Language or Inclusive Learning); (b) barriers (i.e., factors identified by participants that may prohibit or limit implementation of Inclusive Language or Inclusive Learning); (c) implementation drivers (i.e., resources or factors identified by participants that assisted in removing barriers or supporting the exploration, installation, implementation of Inclusive Language or Inclusive Learning). Implementation drivers were further organized within the strand of Implementation Drivers depicting the organizational capacity they improved: (a) Competency (i.e., improvements to the competence and confidence of practitioners); (b) Organization (i.e., factors that create a more welcoming environment; and (c) Leadership (i.e., responsible persons that determine priorities and implementation; Bertram et al., 2014). While each question in the implementation questionnaire addressed an area of implementation (i.e., Question 1: Opportunities, Question 2: Barriers,

Question 3: Implementation Drivers), I looked across all three questions to identify opportunities, barriers, and implementation drivers.

Researcher Reflexivity. Qualitative research is inherently subjective, as researchers contribute their expertise and viewpoints to data collection analysis (Bal & Trainor, 2014). Therefore, I sought to ensure a diverse qualitative analysis team to limit bias and provide a holistic understanding of participant-identified opportunities, barriers, and drivers to implementation. The coding team was diverse in experience and expertise and comprised (a) me (a White man), (b) a first-year doctoral student in Special Education (a White woman), and (c) a first-year doctoral student in Educational Equity (a Black woman). I previously worked with nonprofit agencies, the second researcher previously served as a secondary special education teacher for students with IDD, and the third researcher previously served as a licensed clinical social worker for individuals with Mental Health and IDD diagnoses. The third researcher was the parent of a youth with autism. In addition, the research team held religious diversity: the third researcher identified as an active Christian in the Baptist faith, the second researcher identified as a nonpracticing Catholic, I identified as a practicing Jew.

First, the coding team conducted initial coding of responses and identified subcodes within three main structural codes (i.e., opportunities, barriers, drivers). Next, the coding team met to discuss, came to consensus on, and defined subcodes within the structural codes. I shared subcodes with two members of the dissertation committee with experience in secondary transition and religious participation of youth with IDD. The coding team recoded qualitative responses using the agreed upon subcodes. Each team member served as the primary coder for approximately one third of all qualitative responses ($N = 40$). In addition, all team members secondary coded all responses for which another team member served as the primary coder. Last,

the team met to organize findings according to subcodes. Qualitative team members aimed for dialogic intersubjectivity throughout the coding process rather than intercoder agreement (Kvale & Brinkmann, 2009; Lawless & Chen, 2019).

3.10 Interrater Reliability

Intervention data were automatically tracked on Canvas. Canvas LMS recorded (a) participant usage logs (i.e., date and time participants access lesson pages, participant time spent in lesson); (b) participant answers to knowledge tests; and (c) participant ratings on confidence tests. While this method provides automaticity to scoring, interrater reliability was needed to ensure the system records responses correctly (Krippendorff, 2004). I ensured all participant responses were scored and recorded correctly by verifying hard copies printouts of participant responses. A second observer (i.e., research assistant) conducted interrater reliability (IRR) by reviewing a minimum of 30% of participant answers to knowledge and confidence tests to ensure (a) tests are scored correctly within Canvas and (b) scores are correctly recorded within the Canvas gradebook (Krippendorff, 2004). The IRR must be at least 90% to be considered reliable as this ensures efficacy of the computer-based scoring process (Halgren, 2012; Krippendorff, 2004). IRR was calculated by dividing the number of agreements by the number of agreements plus disagreements, multiplied by 100.

First, the research assistant and I practiced scoring three example responses independently according to the rubric. Then, we met to calculate a practice interrater reliability score, review our scores, discuss discrepancies, and agree upon scoring procedures. Our average IRR for the practice session was 93% (range = 87%–96%). Next, we came to a consensus on scoring procedures and rescored the three example responses. Average IRR for this session was

100%. Last, the research assistant scored at least 30% of all responses independently based on consensus scoring criteria.

3.10 Procedures

Prior to recruitment, I obtained Institutional Review Board (IRB) approval. I determined sample size by conducting a power analyses for knowledge and confidence measures using GPOWER 3.0 software (Fraul et al., 2007). I used a large effect size (g = 1.0) and alpha of .05 in the analysis, which resulted in a suggested sample of 60 participants. The large effect size was estimated based on similar studies examining the effects of online professional development on knowledge and confidence for participants with no prior formal training in the area (e.g., parents raising children with IDD; Burke et al., 2016).

Recruitment

Religious congregations belong to assorted organizing bodies, are often partially or fully autonomous, and use varying terms to describe similar positions (e.g., minister, Rabbi, director; Pew Research Center, 2015). Because of this varied nature and lack of a centralized entity for communication and recruitment (e.g., local education agency), I chose to contact individual leaders as the principal recruitment means. This method typically results in a response rate around 10% (Fan & Yan, 2010). Therefore, I compiled a list of 600 leaders in the mid-Atlantic and Southeast regions of the United States that matched inclusion criteria by (a) searching for faith communities across faith traditions and denominations within a 400-mile radius of my area and (b) contacting the leader who matched the initial inclusion criteria (if such a leader was listed at the congregation). I sent each potential participant an email explaining the (a) purpose of the study, (b) the time commitment required of participants, and (c) the randomization process. I ended the email by encouraging the potential participant to forward the email on to someone who

matched the inclusion criteria if they did not. If the potential participant did not return contact within two weeks, I sent a follow up email. In addition, I posed an announcement on personal social accounts and social media groups where members were likely to meet inclusion criteria (e.g., Facebook group for clergy in a particular denominational conference). I began contacting potential participants on November 17, 2020 and received commitments from 62 participants by January 3, 2021. An additional nine participants responded to contact initiations and agreed to be in the study by January 10, 2021.

Randomization. I initiated randomization procedures after exceeding the target sample size in written commitments (i.e., 62). Within seven days of conducting the first round of randomization, an additional nine participants committed to the study. Therefore, I conducted two rounds of randomization with identical procedures. I used a block randomization technique, which is a method that allows researchers to build equivalent groups while maintaining randomization (Kang et al. 2008). This method provides researchers with enough power to measure differences across participant characteristics, which is valuable given the small sample size in this study (Kang et al., 2008). I coded participants by: (a) cultural background (i.e., Black, Latinx, Asian, Native Hawaiian/Other Pacific Islander, American Indian/Alaska Native, White, Other); (b) faith tradition of the religious organization or congregation (i.e., Mainline Christian, Evangelical Christian, Catholic, Jewish, Muslim), (c) participant role within the congregation (i.e., clergy member without youth/young adult responsibilities, clergy with youth/young adult responsibilities, religious education director), and (d) setting (i.e., urban, rural, suburban, college campus) within the participant list stored in Microsoft Excel. Next, I randomly sorted participants by these characteristics in the order listed using the RAND and SORT macros of Microsoft Excel. I created 18 blocks of four participants that shared identical characteristics.

Two blocks contained three participants because there were not enough participants with identical characteristics to form a full block.

Assignment. After randomizing participants to blocks, I used the RAND and SORT macros in Microsoft Excel to randomly assign one of four letters to each person in a block (i.e., A, B, C, D for the first round of randomization; E, F, G, H for the second round of randomization). Following random allocation procedures (Kim & Shin, 2014), I wrote the letter representing each group on a slip of paper and placed the four slips of paper in an empty bowl and shuffled the pieces of paper within the bowl. My spouse (who did not know which groups participants were assigned to) drew two groups each time to be assigned to the treatment group. Thirty-six participants were assigned to the treatment group and 35 participants were randomly assigned to the control group.

Pretest

First, participants in both groups were invited via email to join the course and create a personalized Canvas login using their email address. Participants assigned to the treatment group were invited to join a Canvas course with the pretest, posttest, and ROLLING PD materials. Participants assigned to the control group were invited to join a Canvas course with just the pretest and posttest. Next, all participants completed a tutorial on the Canvas interface. This ensured participants understood how to navigate the LMS and completed data collection measures. After this, participants checked their learning by taking a five-question quiz containing questions about Canvas navigation (e.g., “What do you do if you need technical assistance?”). The mastery criteria was scoring 5 questions correct on the quiz. If participants did not meet mastery, they were instructed to review the tutorial and complete the quiz again. They repeated this procedure until they scored 5 out of 5. The training lasted approximately 10 min. Once

participants completed the tutorial and quiz, all participants were prompted to complete the pretest assessments. All participants completed: (a) the knowledge pretest, (b) the confidence pretest, (c) the Dimensions of Belonging rating, and (d) a demographic questionnaire. After completing all four parts, participants assigned to the treatment group proceeded to intervention and participants assigned to the control group were instructed to wait for a notification to return to the course and complete the posttest. The Canvas course used stepwise logic so that participants could only complete the next task after finishing the current task in the course.

Intervention

Participants assigned to the control group did not complete the intervention procedures. Participants assigned to the treatment group began intervention after completing the pretest. The intervention was the ROLLING PD, which comprised six content lessons teaching two Inclusion characteristics (i.e., Inclusive Language, Inclusive Learning). Each lesson taught one component of each Inclusion characteristic. Lessons were organized into two units based on the Inclusion characteristics, with three lessons in each unit (i.e., Unit 1: Inclusive Language, Unit 2: Inclusive Learning). Each lesson followed the same format through sequential repetition and allowed participants to organize their learning (Cooper et al., 2020).

First, participants watched a video that (a) provided explicit instruction on one component of the Inclusion characteristic; (b) described examples and non-examples of applying the component in a religious congregation; and (c) reviewed lesson content. Then, participants viewed supplemental material to enhance application of lesson components to religious congregations (e.g., video, article; approximately 5 min). Participants repeated this process for each lesson, completing two lessons per week for a total of six lessons. Participants were provided with guided notes to organize their learning for each lesson. The guided notes ended

with reflection questions for participants to consider for implementing the lesson content in their religious congregation. The ROLLING PD incorporated elements of high-quality online asynchronous PD by (a) prioritizing flexible independent learning (Brooks, 2010); (b) incorporating content identified as needed by participants (Stewart-Ginsburg et al., 2020; Walters et al., 2017); (c) including content with relevant contextualized examples and nonexamples (Walters et al., 2017); (d) allowing participants to access materials after course completion (Borup & Evmenova, 2019); and (e) adhering to QualityMatters design standards (QualityMatters, 2018). Participants in the treatment group were encouraged to complete two lessons per week for a targeted intervention time of three weeks.

Unit 1: Inclusive Language. The first unit comprised Lessons 1, 2, and 3. This unit taught participants how to "develop a receptive [congregational] atmosphere for including students with disabilities by educating administrators, teachers, other staff, and students about person-first language and disability rights" (Rowe et al., 2015, p. 120).

Lesson 1: Inclusive Language. In the first lesson, participants were taught ways to promote inclusive language. The lesson taught (a) models of disability (i.e., medical, social); (b) examples of person-first and identity-first language; and (c) appropriate circumstances to use person- and identity-first language (Dunn & Andrews, 2015).

Lesson 2: Inclusive Communication. In the second lesson, participants were taught terms to use in promoting communication with families raising youth and young adults with disabilities. This content is important as communication between religious leaders and parents raising youth and young adults with IDD remains a mutually perceived barrier to participation (Carter, Boehm, et al., 2016; Stewart-Ginsburg et al., 2021). The lesson provided instruction on (a) the process and reason for an Individualized Education Program (Zirkel et al., 2019), (b)

components of accommodations for youth and young adults with IDD in classrooms and congregations (Accardo et al., 2019), and (c) components of modifications for youth and young adults with IDD in classrooms and congregations (Accardo et al., 2019).

Lesson 3: Social Skills. The third lesson taught participants how to provide social skills instruction. Participants learned how to identify, teach, and review social skills in religious congregations (Walker & Barry, 2018). After completing this lesson, participants completed the first end-of-unit qualitative implementation questionnaire.

Unit 2: Inclusive Learning. The second unit comprised Lessons 4, 5, and 6. The second unit taught participants how to "provide professional development…to use universal design for learning and evidence-based instructional strategies" (Rowe et al., 2015, p. 120).

Lesson 4: Multiple Means of Representation. In the fourth lesson, participants watched a video providing an overview of UDL (CAST, 2018). Next, participants were taught how to provide multiple means of representation for individuals with disabilities in religious congregations (e.g., pairing spoken cues with visual cues in worship, providing background knowledge; CAST, 2018).

Lesson 5: Multiple Means of Action and Expression. In the fifth lesson, participants were taught how to provide multiple means of action and expression for individuals with disabilities in religious congregations (e.g., offering a choice between saying a prayer or writing a prayer, using response cards to participate in a worship service; CAST, 2018).

Lesson 6: Multiple Means of Engagement. In Lesson 6, participants were taught how to provide multiple means of engagement for individuals with disabilities in religious congregations. In addition, participants were taught how to teach volunteers how to provide multiple means of engagement (e.g., posting expectations in the sanctuary, planning examples to

use in a Sunday School lesson; CAST, 2018). After completing this lesson, participants completed the second end-of-unit qualitative implementation questionnaire.

Posttest

Participants assigned to the control group were invited to complete the posttest three weeks after they completed the pretest tasks. Participants in the treatment group completed the posttest after they finished all lessons (M = 33.15 days; SD = 19.17). Posttest tasks comprised: (a) the Knowledge posttest, (b) the Confidence posttest, and (c) the Dimensions of Belonging rating posttest. Additionally, participants in the ROLLING condition completed the social validity questionnaire.

3.11 Procedural Fidelity

I ensured procedural fidelity. The ROLLING PD comprised preset videos, activities, and lesson pages. I used step logic that required participants in the treatment group to complete each step within each lesson (e.g., view video, finish activity) in sequential order prior to advancing to the next step or lesson. Asynchronous training opportunities with these components inherently ensure a high level of procedural integrity as the intervention package is fixed (Gerencser et al., 2020). In studies involving asynchronous training, procedural fidelity is needed to determine that (a) the training system is operational and (b) participants correctly complete all steps within the study phase (Gerencser et al., 2020). These components are described in the Procedural Fidelity Checklist (see Appendix F). I calculated procedural fidelity by dividing the number of correctly implemented components by the total number of components and converting the ratio to a percentage.

CHAPTER 4: RESULTS

I implemented a waitlist randomized control trial design (Boruch, 1997; Gersten et al., 2005) to explore three research questions, including (a) the effects of ROLLING PD on religious congregation leaders' knowledge and confidence implementing Inclusive Language and Inclusive Learning; (b) the opportunities and barriers to supporting youth and young adults with IDD in religious congregations identified by religious leaders as a result of this training; and (c) how religious congregation leaders perceive this training. The intervention provided explicit instruction on how to implement characteristics of Inclusive Language and Inclusive Learning (Rowe et al., 2015) in a religious congregation and comprised six lessons across three scheduled instructional weeks.

4.1 Procedural Fidelity

Participants were invited to join the online Canvas course, create a personalized account, and begin completing pretest assessments on January 4, 2021. Participants in the treatment group accessed lessons at their own pace between January 11 and April 25, 2021. Participants in both groups completed pretest and posttest assessments between January 4 and April 25, 2021. The average number of days between pretest and posttest was 33.15 days (SD = 19.17) for the treatment group and 33.73 days (*SD* = 16.90) for the control group). Procedural fidelity for all participants was 92% (range 38–100%). Two features of the experiment promoted procedural fidelity: (a) all training content was preset through the Canvas course and (b) the course featured stepwise logic that prohibited participants from not moving on to future steps or lessons prior to completing the current step or lesson (Halgren, 2012; Krippendorff, 2004). Therefore, participants who completed the study (*n* = 49) had 100% procedural fidelity. Procedural fidelity was impacted by 11 participants (i.e., nine treatment group participants, two control group

participants) who did not complete the study and were counted as attrition (procedural fidelity range 38–83%). The research assistant conducted IRR using the consensus scoring guidelines. IRR remained at 100% across 32.1% of responses (n = 35) in the training and control group in both pretest and posttest responses after consensus, resulting in a total IRR score of 99.32%.

4.2 Participants

Sixty leaders participated in this study. Seventy-one leaders agreed to participate in the study, but eleven leaders did not accept the invitation to join the Canvas course, did not complete the pretests, and did not respond to multiple contact attempts soliciting their participation. These 11 leaders were classified as non-participants, resulting in a total sample size of 60. Forty-nine participants (81.7%) completed all parts of the study. Eleven participants (18.3%) completed pretest tasks but did not finish participation in the study. This included nine participants (15.0%) in the treatment group and two participants (3.3%) in the control group, resulting in a total attrition of 18.3% and a group differential attrition of 11.7%. Data from these 11 participants (i.e., pretest, demographic characteristics) are included in the quantitative analysis (further described in Section 4.3, Data Screening). Three leaders completed the first three lessons of the ROLLING PD and Unit 1 questionnaire. Data from these participants are reported in the qualitative results (refer to Section 4.5).

Participant Characteristics

Participant demographics are reported in Table 4.1 The majority of participants: (a) identified as White/Caucasian (n = 49; 81.7%); (b) held primary responsibilities with youth or young adults (n = 29; 48.3%); and (c) served as a non-ordained/lay religious education director (e.g., youth advisor; n = 23; 38.3%). Other participants served as Senior/Lead Clergy (e.g.,

Senior Rabbi; *n* = 20; 33.3%) or Assistant/Associate Clergy (e.g., Associate Pastor; *n* = 17; 28.3%). The average age of participants was 36 years (*SD* = 12; range = 20–70).

Table 4.1
Participant Demographics

Characteristic	*N* = 60	%
Participant pronouns		
She/her	39	65.0%
He/him	19	31.7%
They/them	1	1.7%
Other	1	1.7%
Participant age		
20–29 years	21	35.0%
30–39 years	15	25.0%
40–49 years	14	23.3%
50–59 years	5	10.0%
50–70 years old	3	5.0%
Missing	1	1.7%
Cultural background		
White/Caucasian	48	81.7%
Black/African American	5	10.0%
Latinx/Latina/o/Hispanic	1	1.7%
Two or more backgrounds	2	3.3%
Other	2	3.3%
Faith tradition		
Christian: Protestant	40	66.7%
Jewish	14	23.3%
Christian: Catholic	5	8.3%
Unitarian Universalist	1	1.7%
Participant role		
Religious education director	23	38.3%
Senior/Lead Clergy	20	33.3%
Associate/Assistant Clergy	17	28.3%
Youth and young adults are….		
my primary or sole responsibility	29	48.3%
one part of several responsibilities	22	36.7%
supported by people I supervise	7	11.7%
not a part of my responsibilities	2	3.3%

Table 4.2 reports participants' preparation and experience. Participants indicated: (a) their years of experience supporting youth/young adults in religious congregations (*M* = 9.57; *SD* = 7.12; range = 1–30); (b) their years of experience in their current role or a similar role (*M* = 6.67;

SD = 6.52; range = 1–37). To prepare for their role, most participants attended or were attending a seminary/clergy preparation program (e.g., Master of Divinity; *n* = 34; 56.7%). Twenty-one participants (35.0%) identified as a parent, sibling, child, or close friend of a person with IDD.

Table 4.2

Participant Preparation and Experience

Characteristic	*N* = 60	%
Experience with youth/young adults in religious congregations		
Fewer than five years	19	31.7%
Between five and 10 years	20	33.3%
Between 11 and 20 years	18	30.0%
Between 21 and 30 years	7	11.7%
Experience in a current or similar role		
Fewer than five years	28	56.7%
Between five and 10 years	21	35.0%
Between 11 and 20 years	10	16.7%
21 years or more	1	1.7%
In preparation for my current role, I attended/am attending...		
seminary/clergy preparation program	34	56.7%
I did not complete formal training for this role	15	25.0%
an undergraduate program on religious education	6	10.0%
a graduate program on religious education	5	8.3%
I am the parent, sibling, child, or close friend of a person with IDD.		
Yes	21	35.0%
No	35	58.3%
Not reported	4	6.7%

Congregational Characteristics

Table 4.3 lists demographics of the religious congregations participants served. Most congregations were located in a suburban area (*n* = 25; 41.7%) and were medium-sized (*n* = 25; 41.7%). Participants represented religious congregations from 14 religious denominations and four nondenominational or unaffiliated congregations. The most common congregational denomination was United Methodist Church (*n* = 15; 25.0%).

Table 4.3
Congregation Demographics

Characteristic	*N* = 60	%
Christian Denomination/Affiliations		
United Methodist Church (UMC)	15	25.0%
Presbyterian Church (PCUSA)	12	20.0%
Roman Catholic Church	5	10.0%
Christian Church (Disciples of Christ)	3	5.0%
Southern Baptist Convention	2	3.3%
Episcopal Church	2	3.3%
African Methodist Episcopal Church	1	1.7%
Anglican Church of North America	1	1.7%
Cooperative Baptist Fellowship	1	1.7%
Presbyterian Church of America (PCA)	1	1.7%
Jewish Denomination/Affiliations		
Reform	7	11.7%
Conservative	3	5.0%
Reconstructionist	1	1.7%
Orthodox	1	1.7%
Nondenominational/Unaffiliated	4	6.7%
Congregational size		
Small	20	33.3%
Medium	25	41.7%
Large	15	25.0%
Urbanicity		
Suburban	25	41.7%
Urban	19	31.7%
Rural	15	25.0%
Missing	1	1.7%

4.3 Data Screening

I collected quantitative data (e.g., knowledge, confidence scores) to answer the first research question and determine the effects of ROLLING PD on religious congregation leaders' knowledge and confidence implementing two essential characteristics of Inclusive Language and Inclusive Learning. Participants completed two assessments (i.e., knowledge [researcher created], confidence [standardized]) prior to and following intervention (i.e., weeks 1 and 5).

Data Screening

First, the data were screened for missing cases, outliers, assumptions, and normality. Eleven participants did not complete the study, resulting in 44 missing data points out of 240 total observations (i.e., individual responses; 18.3%). Therefore, I used an intent-to-treat analysis (McCoy, 2017) to limit threats to internal validity present with a high attrition rate. I conducted a Missing Value Analysis using Little's MCAR with expectation-maximization results. The results of Little's MCAR was not significant ($\chi^2 = 3.034$, $df = 2$, $p = .219$), indicating the data could be treated as missing completely at random. Because the number of missing cases is more than 5%, I used multiple imputation for missing cases (van Buuren, 2012). I created 20 imputations of posttest knowledge and confidence scores (Graham et al., 2007) and used the pooled imputed data set for quantitative analysis. No outliers were detected.

I conducted a Pearson correlation to examine the relationship between knowledge and confidence and ensure instruments were not measuring identical constructs. Scatter diagrams for pretest and were examined and no outliers were detected. Knowledge and confidence scores featured a low correlation at the pretest ($r = -.196$, $p = .133$) and posttest ($r = -.019$, $p = .888$). The results suggest there is little overlap between the outcome measures, which reduces the chances of a Type I error rate for conducting multiple statistical tests.

Group Equivalencies

There were similar proportions of: (a) participants of color in the treatment group ($n = 5$; 17.2%) and control group ($n = 5$; 16.1%); (b) White participants in the treatment group ($n = 23$; 79.3%) and control group ($n = 24$; 77.4%); (c) participants with proximity to a person with IDD in the treatment group ($n = 10$; 34.5%) and control group ($n = 11$; 35.5%); (d) participants in rural settings (versus non-rural) in the treatment group ($n = 7$; 24.1%) and control group ($n = 8$; 25.8%); and (e) participants with high experience (i.e., ≥10 years) in the treatment group ($n = 14$;

48.3%) and control group (n = 14; 45.2%). More participants served as senior/lead clergy in the treatment group (n = 12; 41.4%) than in the control group (n = 8; 24.8%), but more participants served as a religious education director in the control group (n = 14; 45.2%) than in the treatment group (n = 9; 31.0%). A similar number of participants served as assistant/associate clergy in the treatment group (n = 8; 27.6%) and the control group (n = 9; 29.0%). More participants had not completed formal training in the control group (n = 10; 32.3%) than in the treatment group (n = 5; 17.2%), but more participants completed seminary or a clergy preparation program in the treatment group (n = 20; 69.0%) than in the control group (n = 14; 45.2%). A comparable number of participants completed graduate programs in religious/youth education in the treatment group (n = 1; 3.4%) and control group (n = 4; 12.9%) and undergraduate programs in religious/youth education in the treatment group (n = 3; 10.3%) and control group (n = 3; 9.7%). Similar proportions of participants served (a) small congregations in the treatment group (n = 9; 15.0%) and control group (n = 11; 18.3%); (b) medium congregations in the treatment group (n = 12; 20.0%) and control group (n = 13; 21.7%); and (c) large congregations in the treatment group (n = 8; 13.3%) and control group (n = 7; 11.7%).

The treatment and control groups demonstrated equivalent variances in (a) participants of color and White participants (Pearson's test, $\chi^2 = 0.004$, $df = 1$, $p = .951$); (b) participants with and without proximity to a person with IDD (Pearson's test; $\chi^2 = 0.814$, $df = 1$, $p = .367$); (c) participants with various methods of training (Pearson's test, $\chi^2 = 4.464$, $df = 3$, $p = .216$); (d) participants with high (i.e., ≥10 years) and low (i.e., <10 years) experience levels (Pearson's test, $\chi^2 = 0.243$, $df = 1$, $p = .622$); (e) participants in clergy and non-clergy roles (Pearson's test, $\chi^2 = 1.881$, $df = 1$, $p = .390$); (f) participants in rural and non-rural settings (Pearson's test, $\chi^2 = 0.279$, $df = 1$, $p = .598$); and (g) participants who served small, medium, and large congregations

(Pearson's test, $\chi^2 = 0.240$, $df = 2$, $p = .887$). In addition, participant pretest scores did not differ significantly by: (a) participants of color and White participants on knowledge measures (Levene's test, $F_{[1, 55]} = 0.902$, $p = .346$) and confidence measures (Levene's test, $F_{[1, 55]} = 0.028$, $p = .869$); (b) participants with and without proximity to a person with IDD on knowledge measures (Levene's test, $F_{[1, 54]} = 0.760$, $p = .387$) and confidence measures (Levene's test, $F_{[1, 54]} = 0.271$, $p = .605$); (c) participants with various methods of preparation in knowledge measures (Levene's test, $F_{[3, 56]} = 1.328$, $p = .274$) and confidence measures (Levene's test, $F_{[3, 56]} = .768$, $p = .517$); (d) participants with high (i.e., ≥10 years) and low (i.e., <10 years) experience levels on knowledge measures (Levene's test, $F_{[1, 58]} = 1.809$, $p = .184$) and confidence measures (Levene's test, $F_{[1, 58]} = 0.971$, $p = .329$); (e) participants across roles in knowledge measures (Levene's test, $F_{[2, 57]} = 1.316$, $p = .276$) and confidence measures (Levene's test, $F_{[2, 57]} = 0.964$, $p = .388$); (f) participants in rural and nonrural contexts on knowledge measures (Levene's test, $F_{[1, 57]} = 0.701$, $p = .406$) and confidence measures (Levene's test, $F_{[1, 58]} = 0.280$, $p = .599$); and (g) participants serving small, medium, and large congregations in knowledge measures (Levene's test, $F_{[2, 57]} = 0.114$, $p = .893$) and confidence measures (Levene's test, $F_{[2, 57]} = 1.494$, $p = .233$).

Descriptive Statistics

The means, standard deviations, skewness coefficients, and kurtosis coefficients are reported in Table 4.4, participants demonstrated differences in means at posttest. Knowledge scores were higher for treatment group participants ($M = 8.08$; $SD = 3.43$) than control group participants ($M = 6.26$; $SD = 2.48$). Overall confidence scores were higher for treatment group participants ($M = 5.98$; $SD = 0.87$) than control group participants ($M = 4.98$; $SD = 1.27$). Knowledge scores represented a normal distribution at the pretest (skewness = 0.18; kurtosis = -

0.59) and posttest (skewness = 0.40; kurtosis = -0.79). Confidence scores represented a moderate skew at the pretest (skewness = -0.56; kurtosis = -0.55) and posttest (skewness = -1.00; kurtosis = 0.98). It was understood the analysis power was reduced because assumption of normality was not satisfied for the confidence scores.

Table 4.4
Descriptive Statistics

	Treatment Group					Control Group		
	Pretest *M* (SD)	Posttest *M* (SD)	Pretest *M* (SD)	Posttest *M* (SD)	Adjusted *M*	Pretest *M* (SD)	Posttest *M* (SD)	Adjusted *M*
K	6.92 (2.51)	7.09 (3.06)	6.28 (1.96)	8.08 (3.43)	8.26	7.52 (2.84)	6.26 (2.48)	6.06
C	4.84 (1.15)	5.44 (1.21)	4.91 (1.10)	5.98 (0.87)	5.97	4.77 (1.21)	4.98 (1.27)	5.01

Note. K = Knowledge; C = Confidence.

Assumptions for Analysis of Variance

Knowledge and confidence scores met the following assumptions necessary for ANCOVA (Huck, 2012): (a) the groups were independent of one another; (b) the measures were unrelated to each other; (c) the dependent variables were continuous; (d) the independent variables were categorical; and (e) participants were randomly assigned to groups. In addition, the assumption of homogeneous variances was satisfied for the pretest knowledge measure (Levene's test, $F_{[1, 58]} = 2.821$, $p = .099$) and pretest confidence measure (Levene's test, $F_{[1, 58]} = 3.395$, $p = .071$). There was not a statistically significant interaction between the grouping conditions and the pretest, suggesting the assumption of homogeneity of regression lines was met for the knowledge measure ($F = 0.074$, $df = 1$, $p = .787$) and confidence measure ($F = 3.710$, $df = 1$, $p = .060$).

4.4 RQ1: What are the effects of ROLLING PD on religious congregation leaders' knowledge and confidence implementing Inclusive Language and Inclusive Learning?

I conducted two ANCOVAs to determine differences between the treatment group and the control group on knowledge and confidence posttest scores after controlling for pretest scores. Main effects are reported in Table 4.5.

Knowledge

Results of the ANCOVA indicated there was a significant difference for the adjusted pretest scores between the groups ($F_{[1, 54]} = 5.746$, $p = .020$, $\eta^2 = .10$). Repeated measures for knowledge scores are reported in Figure 4.1. Posttest knowledge scores were higher for treatment group participants ($M = 8.08$; $SD = 3.43$) than control group participants ($M = 6.26$; $SD = 2.48$). There was a large posttest effect size between the control group and the treatment group knowledge scores ($\eta^2 = .10$).

Confidence

Results of the ANCOVA indicated there was a significant difference for the adjusted pretest scores between the groups ($F_{[1, 54]} = 16.267$, $p < .001$, $\eta^2 = .23$). Repeated measures for confidence scores are reported in Figure 4.2. Overall confidence scores were higher for treatment group participants ($M = 5.98$; $SD = 0.87$) than control group participants ($M = 4.98$; $SD = 1.27$). There was a large effect size between the control group and the treatment group confidence scores ($\eta^2 = .23$).

Participant Characteristics

Next, I conducted 12 factorial ANCOVAs to determine main effects of participant characteristics on the posttest scores and 12 factorial ANCOVAs to determine interaction effects of participant characteristics and group membership (i.e., treatment, control) on posttest scores. These main effects and interaction effects are reported in Table 4.5.

Cultural Background. Main effects of participants' cultural background were not significant for knowledge scores or confidence scores. Participants of color (i.e., not White) and White participants performed similarly on the knowledge posttest measures when controlling for pretest scores. Interaction effects between participants' cultural background (i.e., not White, White) and group membership (i.e., treatment, control) were not significant.

Proximity. Main effects of participant proximity to a person with IDD were significant for knowledge scores but were not significant for confidence scores. Participants with close proximity to a person with IDD (i.e., participants who indicated they were the parent, sibling, child, or close friend of a person with IDD) demonstrated higher scores at the posttest (M = 7.95; SD = 3.34) than participants who did not have close proximity to a person with IDD (M = 6.32; SD = 2.67). Participants without and without close proximity scored similarly on confidence posttest measures when controlling for pretest scores. Interaction effects between participants' proximity to a person with IDD (i.e., yes, no) and group membership (i.e., treatment, control) were not significant.

Preparation. Main effects of participants' preparation method were significant for knowledge scores but not confidence scores. Leaders performed similarly on confidence measures regardless of preparation method (i.e., seminary/clergy preparation program, graduate religious education program, undergraduate religious education program, no formal preparation). A post-hoc analysis using Tukey's procedure (α = .05) specified the posttest knowledge mean was significantly higher for participants who completed an undergraduate program on religious/youth education than participants who did not complete formal training for their role. There were no significant differences between other methods of preparation (i.e., graduate religious/youth education program, seminary/clergy preparation program). Participants who

completed an undergraduate program on religious/youth education scored highest (M = 9.50; SD = 3.21) compared to participants who completed a seminary/clergy preparation program (M = 7.42; SD = 2.98), completed a graduate program in religious/youth education (M = 6.00; SD = 1.87), and did not complete formal training (M = 5.80; SD = 2.98). Interaction effects between participants' method of preparation and group membership (i.e., treatment, control) were not significant.

Experience. Main effects of participants' experience were not significant for knowledge and confidence tests. Participants with high levels of experience with youth/young adults (i.e., ≥10 years) performed similarly to participants with low levels of experience (i.e., <10 years) when controlling for pretest scores. Interaction effects between participants' level of experience (i.e., <10 years, ≥10 years) and group membership (i.e., treatment, control) were not significant.

Role. Main effects of participants' roles were not significant for knowledge and confidence tests. Participants performed similarly across roles (i.e., Senior Clergy, Associate Clergy, Religious Education Directors) when controlling for pretest scores. Interaction effects between participants' role and group membership (i.e., treatment, control) were not significant.

Rurality. Main effects for participants' context were not significant for knowledge and confidence tests. Participants in rural settings performed similarly to participants in urban and suburban settings when controlling for pretest scores. Interaction effects between participants' setting and group membership (i.e., treatment, control) were not significant.

Congregation Size. Interaction effects of participants' congregation size were not significant for knowledge and confidence tests. Participants who served small, medium, and large congregations performed similarly when controlling for pretest scores.

Table 4.5
Main Effects and Interaction Effects

Outcome	Factor	*F*	*p*	Partial η^2
Knowledge	Group	5.746	.020	.10
Confidence	Group	16.267	<.001	.23
Knowledge	Culture	0.015	.904	<.001
	Proximity	4.076	.049	.07
	Preparation	3.111	.035	.16
	Experience	3.202	.079	<.001
	Role	0.017	.983	<.001
	Rurality	0.001	.982	<.001
Confidence	Culture	2.344	.132	.04
	Proximity	0.048	.827	<.001
	Preparation	1.054	.377	.06
	Experience	1.749	.192	.03
	Role	1.322	.275	.05
	Rurality	0.061	.806	<.001
Knowledge	Culture*Group	0.257	.615	<.001
	Proximity*Group	0.406	.527	<.001
	Preparation*Group	0.453	.729	.03
	Experience*Group	1.713	.196	.03
	Role*Group	0.978	.383	.04
	Rurality*Group	0.644	.426	.01
	Cong Size*Group	2.657	.080	.09
Confidence	Culture*Group	0.946	.336	.10
	Proximity*Group	0.420	.520	<.001
	Preparation*Group	0.435	.729	.03
	Experience*Group	0.560	.458	.01
	Role*Group	0.174	.841	<.001
	Rurality*Group	.668	.417	.01
	Cong Size*Group	0.887	.418	.03

Figure 4.1. Repeated Measures of Knowledge Scores.

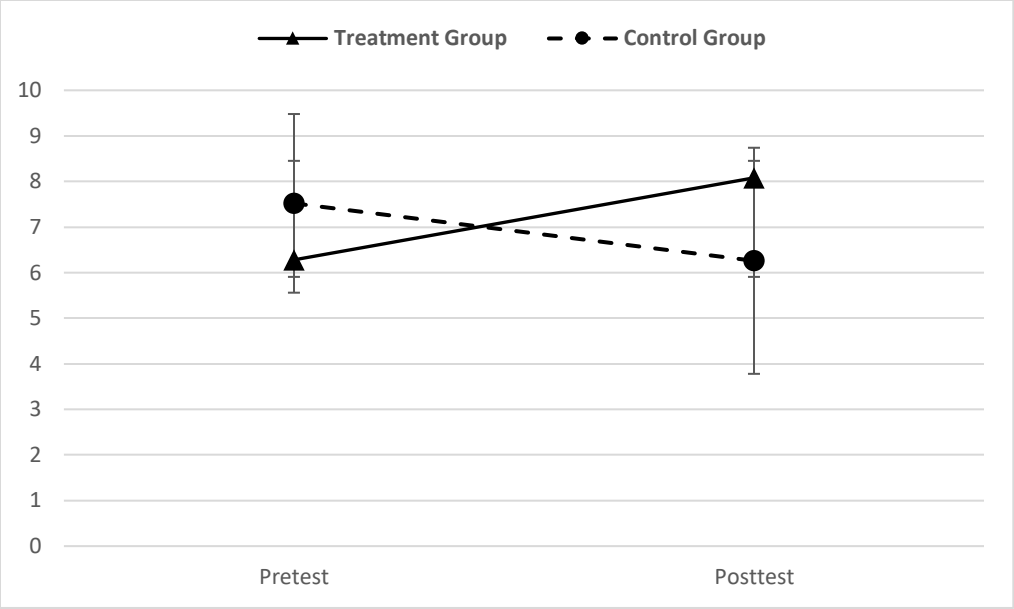
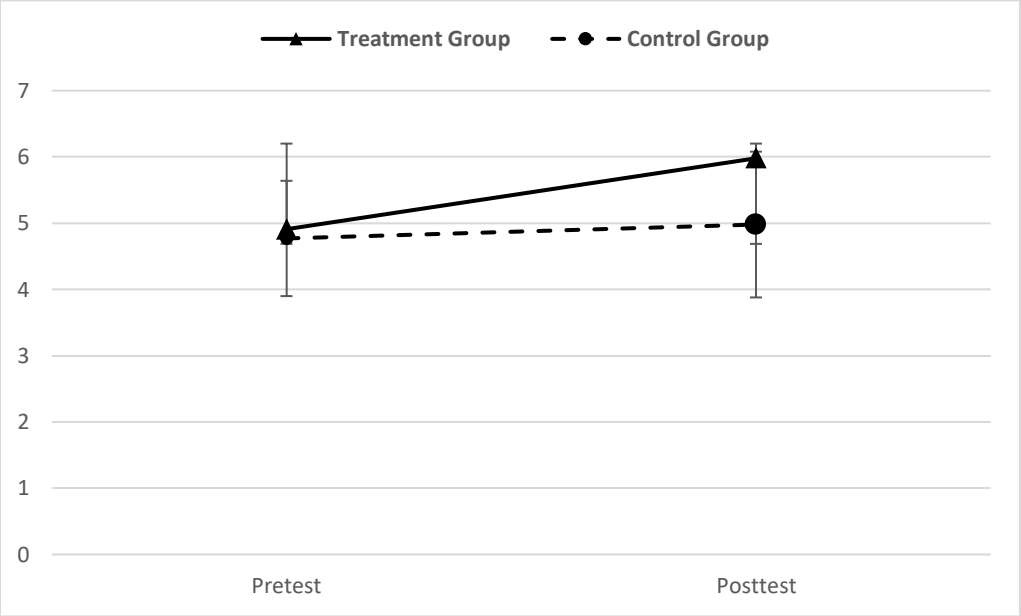


Figure 4.2. Repeated Measures of Confidence Scores.



Summary

Together, these results indicated a difference between the control and treatment group in both knowledge and confidence scores. When compared to pretest measures, participants in the treatment group scored significantly higher in both posttest measures. No interaction effects of

participant characteristics were statistically significant. Leaders who completed the ROLLING PD demonstrated higher levels of knowledge and confidence implementing Inclusive Language and Inclusive Learning than leaders who did not complete the ROLLING PD.

4.5 RQ2: What opportunities, barriers, and implementation drivers do religious congregation leaders identify for supporting youth and young adults with IDD in religious congregations as a result of this training?

I collected qualitative data and used thematic analysis to answer the second research question and categorize the opportunities and barriers religious leaders identified to supporting youth and young adults with IDD in religious congregations as a result of the ROLLING PD training. Participants in the ROLLING PD completed two reflection questionnaires at the end of the Inclusive Language unit (i.e., Lessons 1, 2, 3) and the Inclusive Learning unit (i.e., Lessons 4, 5, 6). In identical questionnaires, participants reflected on and listed: (a) opportunities they identified for implementing unit content in their congregations, (b) barriers they anticipated experiencing when implementing unit content, and (c) factors that would assist them in removing said barriers or implementing unit content. Twenty leaders completed Unit 1 and Unit 2 questionnaires. An addition three participants completed the Unit 1 questionnaire but did not finish the study. Therefore, data from twenty-three participants are included in the qualitative analysis. Participants were assigned pseudonyms (see Table 4.6 for participant demographics).

Two research assistants and I coded participant responses using an inductive structural coding method (Glesne, 2016; Saldaña, 2013) across three aspects of implementation (i.e., opportunities, barriers, drivers; Bertram et al., 2014). Within the themes of Opportunities, Barriers, and Implementation Drivers, the researchers identified and categorized 18 thematic subcodes based on participant responses to implementing Inclusive Language or Inclusive

Learning. Table 4.7 lists the qualitative implementation themes that emerged within each structural code. These subcodes are organized within each aspect of implementation: (a) Opportunities, (b) Barriers, and (C) Implementation Drivers. Responses are delineated within a theme by the corresponding unit (i.e., Inclusive Language, Inclusive Learning) when participants report substantively different ideas between implementing Language and Learning.

Table 4.6

Participant Demographics

Pseudonym	Pronouns	Age	Experience in current role	Cultural Background	Role	Affiliation
Steve	He/him	40	13	White	SC	Disciples of Christ
Agatha	She/her	45	2	White	AC	Disciples of Christ
Natasha	She/her	31	2	White	AC	Reform
Janet	She/her	29	3	White	RED	Non-Denominational
Wendy	She/her	24	5	White	RED	Presbyterian Church (USA)
Betty	She/her	57	2	White	RED	United Methodist Church
Maya	She/her	46	5	White	RED	Roman Catholic Church
Peggy	She/her	27	1	Latinx	RED	Roman Catholic Church
Nick	He/him	41	13	White	SC	Presbyterian Church (USA)
Peter	He/him	38	16	White	AC	Presbyterian Church (USA)
Darcy	She/her	37	3	White	AC	Presbyterian Church (USA)
Jane	She/her	49	12	White	SC	United Methodist Church
Julia	She/her	30	5	White	SC	Presbyterian Church (USA)
Carol	She/her	26	1	White	AC	Reform Jewish
Stephen	He/him	64	37	White	SC	Conservative Jewish
Hope	She/her	60	15	Other	SC	Reform Jewish
Jessica	She/her	32	10	White	RED	Non-Denominational
Tony	He/him	27	7	White	RED	United Methodist Church
Sharon	She/her	24	6	White	RED	Roman Catholic Church
James	He/him	34	1	White	SC	United Methodist Church
Maria	She/her	42	8	Black	RED	Non-Denominational
Pepper	She/her	21	2	White	RED	United Methodist Church
Sam	He/him	41	9	White	SC	Presbyterian Church (USA)

Note. AC = Assistant/Associate Clergy; RED = Religious Education Director; SC = Senior/Lead Clergy.

Table 4.7

Qualitative Implementation Themes

Opportunities	*N*	Example
Inclusive Practices	104	"Make sure our classes have accommodations…"
Advocacy	48	"I can empower volunteers to encourage pairing speaking with gestures during teaching time."
Reflection	32	"…prep for teaching social skills by analyzing our practice and synagogue customs."
Leadership Communication	25	"Educating our team on inclusive language."
Congregational Communication	24	"…starting conversations with parishioners…"
Family Communication	16	"Share with parents the different adaptations we make…"
Barriers	***N***	**Example**
Resources	50	"I don't have partners in this work."
Resistance	37	"There may be some volunteers or other staff that don't want to take extra time or change the regular routine to make these things possible."
Unintended Bias	22	"I believe much of my leadership thinks we're doing a good job of this."
Avoidance/Stuck	22	"Also, just getting people past the "it's the way we are" mentality."
No Barriers	8	"none. will start today!"
Implementation Drivers	***N***	**Example**
Awareness	64	"Changing the culture by educating people, one person at a time."
Accountability	48	"Note taking, some kind of accountability check-ins to see how implementation is going…"
Leadership	40	"I hope to teach thought my own actions, I hope that others will follow."
Resources	33	"I think the use of technology is one of our greatest strengths here."
Next Steps	25	"I think this is something we will definitely be able to consider in implementation and removal of our barriers."
Values	16	"Our church tries to put welcoming first in every way."
Personnel	8	"including other team members with new ideas/goals would definitely help."

Opportunities

Participants described several opportunities to implement Inclusive Language or Inclusive Learning. Researchers categorized these themes within six subcodes. Opportunities included (a) Inclusive Practices, (b) Advocacy, (c) Reflection, (d) Leadership Communication,

(e) Congregational Communication, and (f) Family Communication and Involvement. Within each subcode, we report a description of the theme, number of coded responses, and examples.

Inclusive Practices. We coded responses as Inclusive Practices when participants described actions, policies, and programs that intentionally support youth and young adults with disabilities. This theme was the most frequently coded with 104 responses.

Inclusive Language. Forty-two of these responses concerned Inclusive Language. Participants shared they could "use person-first language," "start checking with people about preferred language (person/identity)," recognize "everyone identifies differently and directly asking someone how they would like to identify shows them that you would like to respect their unique identity as a child of God," and ensure they "Don't always assume someone needs help; ask." Describing a student who was homeschooled, Peggy mentioned, "We can create our version of I.E.P for her, if she doesn't have one."

Other participants described inclusive practices in language. Sam offered, "I definitely liked the idea of starting to retitle our handicapped parking spots to 'Accessible Spots.'" Pepper mentioned she would implement Inclusive Language by,

> Thinking carefully about the language we publish on our website, forms, and other communication about accessibility and people with disabilities. Making sure audio media is captioned and printed media is visually clear and has an audio alternative. Explaining and adhering to schedules more as opposed to telling people to "trust the process", as well as preparing people for and quickly informing them of changes they were not initially prepared for.

Peter shared:

> We should easily be able to use person/identity first language in our worship services, our adult classes and youth group. We already have a few members of our congregation that we have made modifications to our buildings and to our kid's curriculum for, and including your information in the preparations we give our teachers will help them to become even more thoughtful in the way they work with our kids

Peggy mentioned:

> In the next one-on-one that I have with my teen with disability, I could ask her which term she prefers. I could just start by telling her that I'm learning new things and hoping it helps me help her.

Other participants identified opportunities to make accommodations or modifications or provide social skills instruction. Carol offered:

> You can make accommodations, such as hearing aids or large print prayer books during worship, or modifications, such as having a bar mitzvah student illustrate a prayer rather than having to recite it. You can teach people social skills and social norms. If you start each service with a greeting, model and explain for the person what the greeting entails.

Natasha relayed she could:

> Make sure our classes have accommodations, like reading instructions instead of just having them written. Also including a social story so students know what to expect at a given time in class/worship.

Similarly, Wendy summarized:

> Also, when it comes to modification and accommodation just being mindful of the kind of activities planned, in my case for youth group and our elementary groups. For example, when planning games that encourage team building, it might be best to choose a

> game that does not require much physical mobility as to be inclusive to those who might have difficulty in that area. An example of an accommodation could be in Confirmation [Class], instead of writing a faith statement, maybe we allow our students to use art or other platforms to communicate without having to specifically and strictly use words. By offering a worship education in your congregation, this creates a perfect opportunity for both new members to join and learn the social skills needed to actively participate in worship or other regular events, but it also opens the door to those who might feel they need more practice or would simply like to learn more about worship.

Tony reflected:

> One thing I have become more aware of over the years and through this training is the need for an awareness around sensory sensitivity. This has made me more aware of finding ways to modify the way we do worship in our Youth Group - scaled down instruments, calm lighting, etc. I would also like to implement teaching and reviewing social skills and making these reviews a normal part of our weekly routines. That way, newcomers may feel that it's okay to not get it right on their first try, that these skills are always being taught. It also sets up our students to be on the lookout for those learning skills and not be shocked. At different events, worship may include loud music and flashing lights to make the majority of the crowd excited. I may not be able to stop it, but I can certainly still make others feel safe and welcomed.

Sam shared:

> After reviewing the lesson on disabled individuals, I approached a family with an autistic son, and I inquired about his IEP. Immediately, they responded with gratitude that I asked about him and began giving me some ways we can better integrate his view of the world

> into what we do in worship to make him feel welcomed and involved. This lesson has already begun to have a positive effect on the congregation, without them yet fully knowing how and why.

Inclusive Learning. Participants also identified opportunities to use inclusive practices to implement concepts of Inclusive Learning. Maya wondered if she could "change my youth space; when preparing presentations think more about inclusion and active participation for everyone." While Sharon wrote, "Creating Visual schedules for the classrooms and youth events if possible!" Julia noted, "I have also tried to be very aware of representation, and using spoken cues and gestures instead of just assuming people know what is next."

Darcy reflected:

> I like the idea of encouraging folks to repeat what book of scripture I'm reading from, as well as the chapter as a means of being engaged with the service. I also love the idea of providing more structure for community engagement--like taking the time to learn highs and lows from at least two different folks in the community during the "passing of the peace" time to encourage relationship instead of solely casual greetings.

James shared he could "Prepare small groups with all the different ways we have learned in this unit to engage all participants." Tony communicated the perceived benefit of Multiple Means of Representation and Multiple Means of Engagement in religious congregations:

> Posting expectations and giving examples/non-examples both seem like such beneficial general practices for leadership. Both are things that I have used for success in engagement but never truly thought about why I applied them when I did. I think making these practices the norm in my ministry could benefit people with and without disabilities and make it natural for someone with disabilities to hop right in. In terms of expression, I

> notice that many students feel uncomfortable opening up or sharing thoughts and ideas. Mostly, these things are expected to be a verbal response. In the past, I have used multiple means of expression in lessons but, again, never truly thought about the 'why?' I think encouraging drawing or writing in our expected responses would be incredibly beneficial for all students. It still promotes expression, critical thinking, and engagement. It could even lead to help students feel more comfortable with sharing.

Maria echoed these ideas: "Also, children can be encouraged to write, speak, or draw their prayer needs. Jane conveyed, "I think giving people many ways to respond (writing prayers, etc.) is part of any well-designed worship experience, so being careful to include those opportunities more often in worship might help everyone, including persons with disabilities." Janet noted she could focus on:

> Increasing multiple means of representation (being more aware of how we describe transitions/worship and using more non-verbal cues); providing more ways for students to write or draw things. I feel like we do a good job of providing and posting expectations – but could benefit from having these in writing.

Wendy proposed several opportunities to implement Universal Design for Learning principles, including "Encouraging people to respond to prompts in the comments via auditory instruction and on-screen textual instruction during virtual gatherings, providing different ways (written, oral, artistic) to engage with the practices and lessons during and after the gatherings;" "Providing people with resources ahead of time to complete tangible follow-ups to the gatherings;" "Displaying photos or other visual aids on screen during recorded gatherings or at in-person gatherings;" "Providing people with the agenda for community events ahead of time;" and "Providing spaces for people who are easily overwhelmed by sound and light to go and

decompress when they need to, as well as trying to make spaces generally accommodating for people who are sensitive to stimuli." Natasha identified opportunities to implement Inclusive Learning in virtual events, offering she could:

> Have teachers write out instructions and share in the chat at the same time they are sharing verbally Let students respond verbally, with hand gestures, in writing, on a [Google] Jamboard that is anonymous.

Sam summarized:

> Though it is my vacation week, I have already gone into the church office to inform the office manager (who types our weekly Order for Worship and bulletin) that we will be thinking about ways to implement new ideas and shift some of our current worship practices to become more involving of those with a variety of physical or mental conditions. I am looking forward to working with them to devise some icons that will be able to use to help people to know what is about to happen in worship (sit, stand, sing) as well as to begin making strides towards getting them involved in the actual lay-leadership of our time together through written prayers.

Advocacy. We coded responses as Advocacy when they described opportunities for stakeholders (e.g., leaders, parents, youth with disabilities, others, congregation) to support or recommend changes or improvements to day-to-day operations and programs in the congregation and community to support youth and young adults with disabilities. Forty-eight responses matched this theme.

Inclusive Language. Most responses coded as Advocacy described implementing Inclusive Language (n = 23). Wendy saw opportunities to "encourage people around you to use person first language as a good rule of thumb if they are unsure of how to refer to someone with

a disability." Maria shared she considered "Modifying certain activities, creating access to physical spaces, and empowering persons with disabilities to contribute their resources are ways to remove barriers." Some participants viewed advocacy as a part of their role within the religious congregation. Jane saw an opportunity to "Teach primary leaders and discipleship teachers to ask about communicating with person-first or identity first language." Similarly, Peggy relayed an opportunity to advocate for a youth with a disability: "I can also have a conversation with her or just her mom about an I.E.P.," and Pepper noted one way to implement Inclusive Language was "Having direct conversations with college students about how we can best serve them." Nick reflected, "Breaking down these preconceived notions will take time but will ultimately lead to a more welcoming environment."

Inclusive Learning. Maria shared, "As a nursery director for my church, I can empower volunteers to encourage pairing speaking with gestures during teaching times." Peggy shared:

> I can make it clearer what we're doing and when during our youth nights. I share a 'schedule' with our CORE and Teen Leaders but I could also post it for everyone else to see when arriving. That way everyone knows where our night is headed and when.

Maria offered:

> I have learned that different people identify as a 'person with autism,' and others identify as 'an autistic person'. I can respect them is to ask what they prefer and referring to them as such, and to treat them with the dignity they need and deserve.

Reflection. We coded responses as Reflection when participants described chances to self-assess, reflect, and consider ways the leaders and congregation can improve support for youth and young adults with disabilities. Thirty-two responses matched this theme.

Inclusive Language. Julia indicated, “I realized that so often we just assume people know what to do in worship, when that is not the case.” Hope wrote she could “prep for teaching social skills by analyzing our practice and synagogue customs.” Tony opined, “These lessons have made me aware of how easy it can be to not feel included,” and Betty stated, “I can be more aware of the needs of all of my youth members.”

Inclusive Learning. Julia conveyed, “I have also tried to be very aware of representation, and using spoken cues and gestures instead of just assuming people know what is next.” Tony wrote the lessons helped him consider the rationale for his actions:

> In terms of [Multiple Means of] expression, I notice that many students feel uncomfortable opening up or sharing thoughts and ideas. Mostly, these things are expected to be a verbal response. In the past, I have used multiple means of expression in lessons but, again, never truly thought about the “why?” I think encouraging drawing or writing in our expected responses would be incredibly beneficial for all students. It still promotes expression, critical thinking, and engagement. It could even lead to help students feel more comfortable with sharing.

Leadership Communication. We coded responses as Leadership Communication when participants described opportunities for clergy, staff, or representatives to share with other leaders (e.g., committee chairs) and/or lead by example. This theme emerged 25 times.

***Inclusive Language*.** Peter shared, “Just explaining what this [i.e., Inclusive Language] means would make a great sermon and kick off making this small change.” Wendy and Tony conveyed the importance of “Educating our team on inclusive language” and “Teaching through the eyes of a newcomer, a reminder that these skills had to be learned for them to become second-nature, teaching leaders to set the example.” James described an opportunity to share

with members of his college religious education program leadership team: “Initially, we can begin having the conversation with our student leaders, and review this material together to see what it is that we do on a regular basis that needs to be better communicated and accommodating to all students.” Darcy communicated how she already acted on an identified opportunity: “I've already spoken with our Children's Ministry Director and plan to speak with our Youth Director about including specific questions on the paperwork we have parents complete for their children every year so that we can offer to come alongside their child in attaining their IEP goals.” Agatha offered:

> I think that all of the topics could be used during a teaching staff training session to help create a culture of inclusivity. These lessons are also helpful for church leadership retreats/trainings, as well as helpful in summer camp counselor training programming or Vacation Bible School training setting. The Person-first and Identity-first language would be very helpful in equipping not only pastoral/church staff members and teaching teams, but also among church leadership such as elders/deacons.

Inclusive Learning. Similarly, Julia described acting on an identified opportunity to implement Inclusive Learning through Leadership Communication: “I have already begun to do so, by providing backstory” when reading scriptures, which was an example listed within Multiple Means of Representation (i.e., Lesson 4). James offered that he could “Prepare small groups with all the different ways we have learned in this unit to engage all participants.” Sam shared, “In order to implement these ideas, I would love for more members of the congregation I serve to be able to participate in learning and lessons like this.”

Congregational Communication. We coded responses as Congregational Communication when participants chances to share insight directly with the congregation or gather insight from the congregation. Twenty-four responses matched this theme.

Inclusive Language. Maya suggested she could implement Inclusive Learning by "starting conversations with parishioners." Nick proposed: "Also, though I've already done some congregational work around making our church more welcoming to folks with disabilities, I think continuing to promote inclusive language within our faith community, perhaps by even screening some of the videos shared, would help to further that work." Darcy wrote that she could share the ROLLING videos: "Also, though I've already done some congregational work around making our church more welcoming to folks with disabilities, I think continuing to promote inclusive language within our faith community, perhaps by even screening some of the videos shared, would help to further that work."

Inclusive Language. Wendy surmised one way to implement Inclusive Language is "Asking whoever is doing the welcome to clearly explain everything that will be happening in the gathering with physical demonstrations where appropriate and posting the schedule/expectation[s] in the gathering's comments section or at the welcome table." Jane communicated she could "Add a social 'checklist' as part of worship guides to help all our friends follow along with worship."

Family Communication and Involvement. We coded responses as Family Communication and Involvement when participants described opportunities to share insight directly with or gain insight from family members of youth and young adults with disabilities. Sixteen responses matched this theme.

Inclusive Language. Fifteen responses tagged with Family Communication and Involvement concerned ways to implement Inclusive Language. Some participants identified opportunities to use Inclusive Language when communicating with or involving families within religious programs. Maya identified one opportunity as "attending Mass with these families to see where they could use more support." Participants also named ways to communicate with and involve family members of youth and young adults with disabilities in relational ways. For example, Janet reflected: "It [i.e.., the training] also helped me understand the importance of talking with the family members of our students with disabilities and finding out how I can accommodate and help each individual." Hope shared they could engage in "out reach to families to be made aware of what they might experience as missing in our community prep for future accommodation modification (or confirm we are or have done so)." Natasha believed she could "Share with parents the different adaptations we make not just for one student, but which are available to everyone."

Inclusive Learning. One responsee tagged with Family Communication and Involvement concerned ways to implement Inclusive Learning. Sam wondered if "there could be a conversation about this and about other ways we might be able to create a warm and inviting atmosphere for those who are first-time or infrequent visitors all the way to those individuals who have been here for years."

Barriers

In addition to opportunities, participants conveyed barriers that might limit or hinder their ability to implement Inclusive Language or Inclusive Learning. Barriers comprised (a) Resistance, (b) Resources, (c) Unintended Bias, (d) Avoidance/Stuck, and (e) Leader Oversight. Last, leaders occasionally wrote they could not identify barrier in their congregation (i.e., coded

as No Barriers). Within each subcode, we report a description of the theme, number of coded responses, and examples.

Resources. We coded responses as Resources when participants described barriers related to inadequate time, materials, facilities (e.g., physical access), finances, or human capital to fully support youth and young adults with disabilities. Fifty responses matched this theme.

Inclusive Language. Related to barriers implementing Inclusive Language, participants suggested several barriers related to monetary or facility resources. Carol indicated, “Access to proper resources and funds, leadership not understanding the importance of implementing these changes, not knowing what all the needs are or how to ask.” Tony wrote, “The biggest barrier would be a worship setting outside of my control.” Maria opined, “Physical barriers, such as lack of access to facilities can create obstacles for persons with disabilities to fully participate in social settings.” Several participants mentioned financial barriers, which was exemplified in Pepper’s response: “Finances, time, and the additional labor capacity/energy needed.” Similarly, Sam forecast:

> I believe some of the barriers that I might encounter will be monetary and financial issues. I would like us to create better signage around the church campus, which might make accessibility easier for everyone, and the costs that might be involved in this may not be preventative but certainly may slow us down.

Some leaders mentioned a lack of time as a Resource Barrier. For example, Janet stated, “Time is the biggest barrier, as well as the ability to connect with the parents - often parents are busy and don't have time to connect.” Similarly, Natasha posited:

> Time...I don't necessarily have the time to do it, I'll be told that it takes too long to get things on the website etc. My teachers already have trouble doing all of it. Not wanting to

> add “more time” to how long it already takes to do things. I don't have partners in this work.

Other participants described a resource barrier in human capital. Sharon shared:

> The biggest downfall in my ministry is not having enough volunteers for how many students we have -- to implement what I have learned I would want to find more volunteers and then make sure we have leaders comfortable in helping our new friends with acclimating to our group and making sure they can learn in helpful ways to them. Unfortunately, without help, it's me trying to lead 100 students and I don't have the bandwidth to focus on the needs of one student - regardless of what accommodations they need.

Inclusive Learning. Carol reflected on both material and time constraints as resource barriers:

> I think a lot of these strategies require us to plan ahead and think about who is going to be in the room. We need to make sure we have the materials ready and available for use. That is something that can be hard for me, but not impossible, since sometimes I am planning at the last minute.

Sharon perceived facility and time constraints:

> We share spaces with the school and remembering to hang up schedules every week is hard. Also, with a busy schedule having to add another thing to the list is tough!

Maria listed facility barriers, writing “Another barrier to implementing these ideas is how classrooms are constructed.” Echoing human capital resource barriers from Inclusive Language, Julia reported, “Having to bring the rest of my leadership up to speed so that they, too, can know and use such ideas when they are leading or I am away for any reason.”

Resistance. We coded responses as Resistance when leaders described congregational hesitation to make changes to support youth and young adults with disabilities. This theme emerged 37 times.

Inclusive Language. Several participants shared how congregational members might be reluctant to make changes in their language. Jane wittily wrote the biggest barrier was: "Honestly, whiny church people who have no spirit of adventure or understanding of inclusivity or community." Darcy shared: "Congregational resistance, confusion, forgetfulness, etc." Peter conveyed:

> We should easily be able to use person/identity first language in our worship services, our adult classes and youth group. We adopted using gender inclusive language in 2019 and there was very little push back…The biggest thing I could see is a little fatigue at rolling out another conversation about language after our previous big conversation about language right before COVID hit.

Several responses concerned resistance from other leaders in the church. James mentioned a barrier might be "to have everyone on board with learning and actively practicing the plan." Natasha admitted it was "Hard to change things and get people on board." Wendy projected, "There may be some volunteers or other staff that don't want to take extra time or change the regular routine to make these things possible." Several participants addressed barriers specific to implementing social skills instruction. Tony surmised:

> In terms of teaching and reviewing social skills, there may be a constructed expectation that these things are second-nature; that there isn't a need for them to be taught. It may lead to students saying, "Wait, how do you not know this!?" leading to embarrassment and a feeling of being excluded on the newcomer's end.

Stephen echoed this idea:

> "People who already know these [social] skills would be impatient pausing to teach the skills to those who are new or unfamiliar. They might not want to help others learn."

Inclusive Learning. Participants also identified how resistance may become a barrier to implementing Inclusive Learning. Some responses described hesitance from congregational members who enjoy routine. Peter's congregation held worship services online at the time of the study, and he predicted, "I think once we move back to in person worship there will be people who want it to be exactly as they remember it with no changes at all." Sam responded in kind: "Because people embrace the sanctuary as it is (without much room for change), I suspect this could become a barrier to semi-permanent signage."

Mirroring thematic responses in Inclusive Learning, Maria and Janet felt other leaders may be resistant to change. Maria wrote, "Barriers might include volunteers who are unfamiliar with how to communicate with children who have special needs in regards to community, learning, and worship." Janet communicated a potential barrier was "Helping the other people on my staff understanding why and how to implement these."

Several responses in this theme concerned leaders expecting to encounter resistance to implementing specific ideas in Inclusive Learning. Darcy reflected:

> I think sometimes using educational models, like repeating things ala scripture passages as cited above, can be interpreted as patronizing rather than helpful. Adults often seem to think that strategies for scaffolding learning no longer apply to them because they're not in a formal, educational setting. I imagine I might get some pushback if I try that. Also, our passing of the peace already takes quite a bit of time, and we have some crotchety

> folks in the congregation who think the services are too long when it comes to interactions like these.

Similarly, Tony wondered if leaders would resist implementing Multiple Means of Expression:

> Other leaders come to mind in terms of expression. They may want to push vocal responses so there is a flow of conversation. This puts pressure on students and vocal responses tend to be rare. Leaders also tend to fill the silence with their own thoughts, taking critical thinking and engagement out of the process.

Unintended Bias. We coded responses as Unintended Bias when participants described members of their congregation holding inaccurate perceptions or knowledge of what is needed, offered, or required to support youth and young adults with disabilities. We tagged 22 responses with this theme, all regarding implementing Inclusive Language.

Inclusive Language. Wendy communicated the perception of volunteers on making changes to support youth and young adults with disabilities, “They [i.e., volunteers] also might argue that they [i.e., changes] are ‘not needed’ because we don't have people in the congregation with disabilities.” Carol articulated, “Access to proper resources and funds, leadership not understanding the importance of implementing these changes, not knowing what all the needs are or how to ask.” Similarly, Julia shared,

> At the moment, the leadership of my church. I believe much of my leadership thinks we're doing a good job of this. However, from all I've learned thus far, we are not. So it's going to have to be brought up and honestly, it will be about whether or not the other leadership decides to come alongside me in helping to implement such accessibility. I hope to teach through my own actions, I hope that others will follow.

Avoidance/Stuck. We coded responses as Avoidance/Stuck when participants either described lacking perceived ability to implement changes to support youth and young adults with disabilities or unsure of what to do to make changes/implement ideas. Nineteen responses matched this theme.

Inclusive Language. Natasha shared she may run into "Other people not wanting us to have to go out of our way" to make changes. Wendy mentioned, in addition to other barriers, "Also, just getting people past the 'it's the way we are' mentality." Nick described confusion regarding using person-first or identity-first language:

> I'm still a bit fuzzy about the person-first and identity-first language since I understand the difference but I don't know which one I should be using. It sounds like both are applicable depending on what a person prefers so my application from this would be to simply ask what language a person wishes to use.

Inclusive Learning. Julia mentioned a barrier might be "Also, just being unaware or falling back into old patterns." James shared, "It is often hard to make change, and as simple as this change can be, there will be push-back on leading a group with accessibility in mind."

No Barriers. Five participants responded they would not encounter barriers to implement Inclusive Language (n = 4) or Inclusive Learning (n = 3). For example, Jane wrote:

> There's literally nothing else to keep anyone from trying some of these things. They cost no money. It's simply taking time to think and prepare to be a good neighbor to everyone in the room.

Implementation Drivers

Last, participants reflected on factors that may help them implement or remove barriers to implementing Inclusive Language or Inclusive Learning. Seven Implementation Drivers

emerged. Drivers improve either (a) Competence (i.e., ability of religious leaders and congregations to support youth and young adults with disabilities); (b) Organization (i.e., capacity to create a welcoming environment to youth and young adults with disabilities); or (c) Leadership (i.e., responsible persons that determine priorities and implementation of practices and ideas; Bertram et al., 2014). Competency Drivers included (a) Awareness and (b) Personnel. Organization Drivers included (a) Accountability and (b) Resources. Leadership Drivers comprised (a) Leadership, (b) Values, and (c) Next Steps.

Awareness. We coded responses as Awareness when participants described the leader or congregation recognizing the needs of families or caregivers and youth and young adults with disabilities as an implementation driver. This theme emerged 64 times.

Inclusive Language. Many responses tagged with this theme connected increased awareness of youth/young adults with disabilities and their needs to implementation of Inclusive Language. Stephen described building awareness through communication with his congregation: "Help the congregation understand the importance of social skill and why they would need to help others learn them, perhaps by sharing their own stories of how they learned the social skills." Carol noted it would be helpful to:

> Notice when someone has a need or disability and be proactive in asking about it and making them feel welcome in the community. "We are so glad you're here." Changing the culture by educating people, one person at a time. Fundraising efforts for funds, reminding people that it is a need and not a luxury to be accommodating of disabilities, raising awareness through community education classes, sermons, articles published in the bulletin, etc.

Wendy echoed this idea in terms of communicating with youth and young adults with disabilities and her congregation:

> First, by asking people how they would like to identify. Then honoring what they want, whether that be identify first or person first. Also, encourage people around you to use person first language as a good rule of thumb if they are unsure of how to refer to someone with a disability. Also, for those who might say it is unnecessary to offer these kinds of things and focus our attention in this area because we do not know of anyone with a disability in the congregation, you could encourage them that if others in the community knew we took special time to make sure we're inclusive to all that might draw in members of the community. Having open and honest conversations with those volunteering or working with your ministries about why these ideas are important and the opportunities that they open up.

Tony described awareness regarding a specific disability category:

> One thing I have become more aware of over the years and through this training is the need for an awareness around sensory sensitivity.

Inclusive Learning. Natasha described the importance of increasing awareness of religious education teachers on the needs of youth and young adults with disabilities:

> Talk to the teachers, demonstrate examples of how it can be helpful; demonstrate to others how easy it is to participate and how much more participation we get when we provide multiple means of participation. Demonstrate to others how easy it is to participate and how much more participation we get when we provide multiple means of participation.

Similarly, Marie reflected on the importance of repetition in constantly raising awareness:

> What could help is to review and constantly practice these ideas as a leader and empower others to do so. Practice engrains a skill into you, and the more it is done, it will become second nature to any individual or organization.

Personnel. We coded responses as Personnel when leaders described the need for or helpfulness of recruiting and training volunteer, staff, or other leaders to support youth and young adults with disabilities. This theme emerged eight times.

Inclusive Language. Responses with this theme were similar across Inclusive Language and Inclusive Learning. Participants described the perceived need for additional volunteers to support youth with disabilities. Maya maintained "including other team members with new ideas/goals would definitely help." Sharon stated she envisioned "Working harder to recruit volunteers, especially volunteers who are familiar with working with accessibility needs." She restated this theme in her Inclusive Learning reflection: "Delegating a volunteer to type and hang these [schedules] each week!" Nick pointed to this implementation driver when writing about barriers:

> The biggest barrier is almost always buy-in. If I, as a leader in a church, want to change something then I need buy-in and support from the board or session in order to do it. This means I will need to demonstrate the effectiveness and application of something before getting approval.

Inclusive Learning. Sharon restated this driver in her Inclusive Learning reflection, writing about the importance of: "Delegating a volunteer to type and hang these [schedules] each week!" Pepper wrote that "additional staff or volunteers" were needed to implement Inclusive Learning.

Accountability. We coded responses as Accountability when participants described the need to create and engage in consistent opportunities for reflection and assessment of best practices within the congregation. This theme emerged 48 times.

Inclusive Language. Responses in this theme centered on the perceived importance of external accountability from a guide or coach would help them implement Inclusive Language or Inclusive Learning. For example, Darcy wrote, "Note taking, some kind of accountability check-ins to see how implementation is going…," while Hope acknowledged it might be helpful to have "A nudge from this class/training in a few weeks and then again in a few months inquiring how it is going and refreshing of some of the ideas." Julia identified:

> I also believe having some sort of an accessibility audit would be really eye opening; to have a third party come in, experience the worship of the church, and receive the feedback from the person as 1.) this will help me (the pastor) understand where I may be creating hindrances, and 2.) will give the leadership another perspective that is not from inside the church.

Inclusive Learning. Julia restated the desire for external accountability via an external an audit in her Inclusive Learning questionnaire:

> At some point, I believe an accessibility audit of our entire church building, worship, teachings, etc. would be wonderful. I think the leadership might also be more open to hearing and receiving feedback than if it were just coming from me as the pastor.

Resources. We coded responses as Resources when participants described accessing, creating, or sharing relevant materials (e.g., visual schedules) or information (e.g., videos) to support youth and young adults with disabilities. This theme emerged 33 times.

Inclusive Language. Participants shared the desire to have resources in several mediums to facilitate implementation of Inclusive Language. Peter wondered if it would be helpful to have "Perhaps pre-prepared written materials that are in congregation friendly language?" Natasha hoped to "Share some of these videos," Nick described the utility of training resources, such as ROLLING videos:

> Sharing the videos and other lessons will be helpful. For the social skills checklists, the item speaks for itself but will take time to prove its effectiveness in practice.

Similarly, Darcy offered:

> Also, though I've already done some congregational work around making our church more welcoming to folks with disabilities, I think continuing to promote inclusive language within our faith community, perhaps by even screening some of the videos shared, would help to further that work.

Julia shared:

> I truly do love these videos, and in fact am using the three about identity and communicating with my leadership board later this week to begin discussions about how church congregation building can become more accessible to individuals.

Sam conveyed:

> I believe that having others to be able to participate in this kind of forum would both help implement ideas but also assist us to remove barriers because they would understand that we can create an welcoming and accessible environment bit by bit and with less financial anxiety than we might have simply by trying to address the issues on our own.

Agatha reflected an interest in sharing training resources with congregation members: “Perhaps having these training resources you've provided for us located on one Youtube play list or website for ease of access in the future would be helpful - if not already done.”

James connected physical and social accessibility in his reflection:

> As [congregation] becomes more accessible physically for all students, this opportunity will allow us to become more socially accessible to all students that feel led to participate in this campus ministry.

Inclusive Learning. In concert with Inclusive Language reflections, participants communicated a desire for several different resources across mediums to implement Inclusive Learning. Peggy relayed, “I can ensure to make room within the budget to print out the schedule sheets or have it up on the monitor screen at all times” Tony committed to “Include these ideas in leader training and give time to role-play/practice.” Maria surmised, “What could help is to review and constantly practice these ideas as a leader and empower others to do so.” Sam wrote about using technology as a resource to implement Inclusive Learning:

> As mentioned above, I think the use of technology is one of our greatest strengths here. And for a congregation who will likely be unable to integrate media platforms in the physical space of the sanctuary, having some that we might purchase and "loan" for individual worship might be an option and alternative for us to consider. I believe these iPads might also help us to allow children to doodle or to become more active participants (depending upon the day or the moment they may be having). I think this is something we will definitely be able to consider in implementation and removal of our barriers.

Agatha conveyed the importance of resources for training church members:

> As I think about the classroom/small group setting, I think some simple training, much like what was provided in this unit, can help remove some of the barriers that exist. It really is not rocket science -- but rather simple, thoughtful changes that will really help to engage all persons and create a culture of true inclusivity for people of all abilities

Leadership. We coded responses as Leadership when leaders described clergy, staff, or others communicating, guiding, and directing efforts in a congregation to support youth and young adults with disabilities and their families. This theme emerged 40 times.

Inclusive Language. Participants described the impact of improving their own leadership capacity on implementing Inclusive Language. Julia reflected, "I hope to teach thought my own actions, I hope that others will follow." James share it would be helpful to have another leader encouraging implementation: "Possibly a word or interaction from someone other than the campus pastor; and also, words and encouragement from the Board of Directors." James considered offering "Small group, student leadership, and worship team mandatory accessibility and leadership training that includes this information!" Janet relayed the importance of "Talking through it as a team and understanding why it is important." Jane described recruitment as a means of increasing leadership capacity: "Find an educator with expertise in the area and allow them to train leaders and design appropriate service helps."

Inclusive Learning. Participants also mentioned the importance of improving their leadership capacity as a driver to implement Inclusive Learning. Carol offered: "I think also once the clergy and leadership start to model good inclusion practices, it's then up to us to train others to do the same, which could be challenging." Janet articulated, "Definitely scheduling out and committing time to this - I have a lot of responsibilities but this is extremely important to me so I want to make sure I make time to connect with parents."

Tony wrote he could:

> Encourage leaders to express themselves in different ways in training, during Youth Group, and in congregational services. This will help them to engage with their own faith and show students that different means of expression are welcomed and accepted.

Values. We coded responses as Values when leaders described beliefs held by the leaders or the congregation toward actively supporting youth and young adults with disabilities. This theme emerged 16 times.

Inclusive Learning. While the majority of other Implementation Drivers described discrete factors (e.g., acquiring funds, recruiting a volunteer), Values were described as an ongoing Implementation Driver. For example, after describing aspects of Awareness as an Implementation Driver, Wendy added, "However, when we take this approach, we're showing that we want to be inclusive to all even if it doesn't knowingly affect us." Natasha relayed,

> Teach the value of helping kids acquire the social skills through social competence. Honestly that is what we do in [program] (our learning program) and it does match our values so we should be able to implement it and really help create a more inclusive and adaptively successful learning environment.

Sam inferred, "I believe that people have an innate want to help others, but they often do not see the world beyond their own perspectives."

Inclusive Learning. Participants also shared Values as an Implementation Driver for implementing Inclusive Learning. Peter stated, "Welcoming is in our DNA as a congregation, and I think people will be willing to accept changes that allow for greater access." Darcy saw an opportunity to share values by: "explaining that the Passing of the Peace is one of the most

important parts of our service because it allows us to explore fellowship within the bounds of worship would probably help more folks accept it as worthwhile."

Next Steps. We coded responses as Next Steps when leaders described being able to identify the next steps they or their congregation can take to support youth and young adults with disabilities. This theme emerged 11 times.

Inclusive Language. Participants communicated several specific strategies they viewed as next steps. Nick offered, "I found the section on social skills to be especially helpful and to apply to many different situations. I will be exploring the two sites that were linked there." Tony identified:

> I would also like to implement teaching and reviewing social skills and making these reviews a normal part of our weekly routines. Breaking down these preconceived notions will take time but will ultimately lead to a more welcoming environment.

Inclusive Learning. Next Steps to implement Inclusive Learning mostly concerned religious education programs. Natasha responded, "Demonstrate to others how easy it is to participate and how much more participation we get when we provide multiple means of participation." Maya shared, "I've reached out to team members to go over ideas and talk about changing some of our education spaces." Maria wrote, "What could help is to review and constantly practice these ideas as a leader and empower others to do so." Jane was challenged to "Find an educator with expertise in the area and allow them to train leaders and design appropriate service helps." Carol offered:

> I can be more thoughtful in my planning process about means of expression and representation. Teaching other people how to have the same intentionality in their programs could be as simple as a session at a board meeting or a presentation to some

other involved congregants, or putting an article in the bulletin. There are plenty of ways to share the information if we take the time to think about it.

Summary

Within qualitative responses, participants conveyed (a) six categorical opportunities for implementing Inclusive Language and Inclusive Learning (i.e., Inclusive Practices, Advocacy, Reflection, Congregational Communication, Leadership Communication, Family Communication), (b) five categorical barriers that could stop or limit their implementation (i.e., Resources, Resistance, Unintended Bias, Avoidance/Stuck, No Barriers), and (c) seven categorical drivers that could help them implement or remove barriers to implementation (i.e., Awareness, Accountability, Leadership, Resources, Next Steps, Values, Personnel). Leaders identified both intrapersonal factors describing their actions and beliefs (e.g., Reflection as an Opportunity; Avoidance as a Barrier; Awareness as a Driver) and interpersonal factors within their congregation and programs (e.g., Inclusive Practices as an Opportunity; Resources as a Barrier; Personnel as a Driver).

4.6 RQ3: How do religious congregation leaders perceive the ROLLING training?

Last, I used descriptive statistics of social validity measures to answer the third research question and discern how religious congregation leaders perceive the ROLLING PD training (refer to Table 4.8 for social validity responses). Participants completed the social validity questionnaire within the Canvas Quizzes engine. Overall, participants agreed the ROLLING PD was (a) acceptable for their congregation (M = 5.47; SD = 0.61); (b) effective (M = 5.16; SD = 1.01); (c) met their congregation's needs and mission (M = 5.53; SD = 0.84). Participants indicated they would be willing to use the strategies in their congregation (M = 5.11; SD = 0.88).

Table 4.8

Social Validity Responses

	M (SD)
Overall training	
1. The ROLLING training is acceptable for my religious congregation.	5.47 (0.61)
2. Most religious leaders will find the ROLLING training appropriate.	5.60 (0.68)
3. The ROLLING training should prove effective in meeting the stated purpose of training religious leaders to support youth and young adults with disabilities.	5.16 (1.02)
4. I would suggest this ROLLING training to other religious leaders.	5.42 (0.61)
5. The ROLLING training is appropriate to meet my congregation's needs and mission.	5.53 (0.84)
Strategies	
6. I would be willing to use these strategies in this congregation.	5.11 (0.88)
7. This primary plan will not result in negative side effects for persons.	4.84 (0.83)
8. These strategies are appropriate for a variety of children, youth, and/or young adults.	5.42 (0.69)
Timing and engagement	
9. The ROLLING training lessons took me an appropriate length of time to complete.	5.47 (0.51)
10. I looked forward to completing the training lessons.	4.95 (0.78)
Congregational inclusion	
11. Strategies addressed in this training will help our congregation support belonging for youth and young adults with disabilities.	5.47 (0.77)
12. Strategies addressed in this training will help other congregations increase belonging for youth and young adults with disabilities.	5.47 (0.70)

In addition, participants were asked qualitative questions related to social validity on the questionnaire. Participants named several aspects of the training they believed were most beneficial, including "The awareness it created specific to religious communities," learning "about different ways of presenting material and helping people participate," and "the different examples provided of how you might incorporate some of these things, such as the different ways of communication in the expression & action module." One participant commented,

> I think the section on using inclusive language. Words are powerful and I think it's important that we teach our congregations/leadership to use language that lifts people up, rather than pushing people down - even if it's unintentional. The other thing that I REALLY appreciated was that each video segment clearly indicated the amount of time

> it would last...so I knew if I had enough time to complete it, or needed to table it for my next available training time.

Conversely, participants indicated the least beneficial aspects of the ROLLING PD. For example, “it’s hard to retain all the information from week to week,” and “I don't feel like I will remember all of the terms; because I was looking for such practical things to do, I feel like I focused more on the HOW vs the WHAT.” Participants most often shared the most helpful lesson was Lesson 1 (i.e., Inclusive Language; $n = 7$).

Leaders listed four additional topics they would like to see included in future training. Topics suggestions included theology of accessibility, gender differences in disabilities, lessons on responding to inappropriate behavior, and lessons on specific disabilities (e.g., “we have some children with Down's syndrome and behavioral disabilities in our congregation that intimidate volunteers”). Suggested changes included (a) providing materials for other leaders and members of their congregation (e.g., “If the class came with a ‘this is what you give to your congregation’ packet, that would be extremely useful”), (b) lengthening content (e.g., “I think it needs to be padded with more information; even if it’s more videos, still need to soak things in a bit longer for it to really stick”), and (c) creating resources for specific denominations and faith traditions. To illustrate this third theme, one participant commented:

> In the Jewish tradition, using writing and electronics during worship on Shabbat [i.e., sabbath day of rest] are not permitted and the examples did not take this into account. It is hard to know how to show Multiple Ways of Meaning when so many are not permitted in traditional settings.

CHAPTER 5: DISCUSSION

The purpose of this study was to investigate the effects of the ROLLING PD on religious congregation leaders' knowledge and confidence implementing two characteristics of Inclusion in General Education (Rowe et al., 2015) within a religious congregation. Following recommendations from the literature (Ault et al., 2013; Baggerman et al., 2015; Carter, Biggs, et al., 2016; Carter, Boehm, et al., 2016; Francis & Jones, 2015; Stewart-Ginsburg et al., 2020), this study aimed to determine the effects of the ROLLING PD on (a) religious leaders' knowledge and confidence implementing Inclusive Language and Inclusive Learning (Rowe et al., 2015) and (b) the opportunities, barriers, and implementation drivers religious leaders identified for implementing these two characteristics (Bertram et al., 2014). I used a concurrent mixed method design involving a randomized control trial (Boruch, 1997; Gersten et al., 2005) paired with two qualitative implementation questionnaires (Bertram et al., 2014). This chapter will present outcomes from this study according to each research question and themes that emerged from intervention outcomes. Last, limitations, suggestions for future research, and implications for practice and policy will be discussed.

5.1 RQ1: What are the effects of ROLLING PD on religious congregation leaders' knowledge and confidence implementing Inclusive Language and Inclusive Learning?

Training was theorized as a method of removing systemic barriers to participation in religious congregations for youth and young adults with disabilities (Carter et al., 2017). Further, researchers and religious leaders have long called for empirical evaluation of strategies congregations can enact to support people with disabilities (Thornburgh & Rife, 1992). Previous studies identified and operationalized predictors of positive post-school outcomes for youth and young adults with disabilities (Mazzotti et al., 2016, 2021; Rowe et al., 2015; Test et al., 2009).

While several research teams examined how related service providers could implement these predictors (Doty et al., 2020; Stevenson et al., 2016; Test & Cease-Cook, 2012), no peer-reviewed, empirical intervention studies were identified that measure effects of training in implementation of the Predictors of Post-School Success. This study contributes to the literature by demonstrating the effectiveness and relevance of training in characteristics of Inclusion in General Education to religious leaders and suggesting that training in characteristics of the Predictors of Post-School Success may be relevant to non-school professionals who support youth with and without disabilities (Mazzotti et al., 2021).

For this study, there was a significant difference between groups in knowledge posttest scores ($F = 8.278$; $p = .006$) and confidence posttest scores ($F = 14.247$; $p < .001$) in comparison to the control group. Participants in the treatment group demonstrated higher levels of knowledge and confidence than participants in the control group. This indicates the ROLLING PD may be an effective way to increase religious leaders' knowledge and confidence implementing Inclusive Language and Inclusive Learning in congregations. Increasing knowledge and confidence may result in an increase in implementation of Inclusive Language and Inclusive Learning within a religious congregation, as knowledge and confidence are factors associated with competency drivers, which promote implementation fidelity and population outcomes (Bertram et al., 2014). Additionally, religious leaders viewed limited knowledge of strategies and confidence as barriers to supporting youth and young adults with disabilities (Baggerman et al., 2015; Francis & Jones, 2015; Patka & McDonald, 2015; Stewart-Ginsburg et al., 2020, 2021). Only two statistically significant main effects emerged across participant characteristics in the factorial ANCOVAs: knowledge scores were moderated by participant preparation and proximity to a person with IDD. This suggests effects of the ROLLING PD are not significantly

moderated by cultural background, experience, roles, and contexts. However, the small sample increases the chance of a Type II error regarding differences across participant characteristics.

While study results provide initial evidence of effectiveness, knowledge mean scores in the treatment group only increased marginally (pretest $M = 6.28$, posttest $M = 8.08$; 15 points possible), with varying scores (posttest $SD = 3.43$). Scores averaged 53.4% of possible points at posttest and demonstrated an increase of 11.5 percentage points from the pretest. While effective in increasing *overall* knowledge, the ROLLING PD alone does not maximize participants' knowledge in Inclusive Language and Inclusive Learning. Confidence scores increased to a slightly higher degree (pretest $M = 4.91$, posttest $M = 5.98$; 7 points possible). Ratings averaged 85.4% of points possible in the posttest and demonstrated an increase of 15.3 percentage points. The contribution of ROLLING PD may be more in terms of affecting religious leaders' perceived confidence than their discrete knowledge. Item analyses of the knowledge and confidence measures are needed to determine which areas ROLLING PD is most and least effective at increasing religious leaders' knowledge and confidence (e.g., social skills instruction).

5.2 RQ2: What opportunities, barriers, and implementation drivers do religious congregation leaders identify for supporting youth and young adults with IDD in religious congregations as a result of this training?

Adoption of innovative principles and practices hinges upon drivers which, when integrated, facilitate implementation fidelity, implementation consistency, and improved outcomes (Bertram et al., 2014). First, leaders must consider opportunities, barriers, and drivers that will facilitate implementation (Bertram et al., 2014). Next, leaders must assess needs. Indeed, religious leaders, youth and young adults with disabilities, and parents raising children

with disabilities have conveyed supporting youth and young adults with disabilities is an area of need where religious congregations can demonstrate improvement (Ault et al., 2013a; Ault et al., 2013b; Stewart-Ginsburg et al., 2020, 2021; Trealor, 2000). In this study, religious leaders identified six opportunities, five barriers, and seven drivers to support implementation of Inclusive Language and Inclusive Learning. While earlier guides on congregational support for persons with disabilities mostly concerned physical accessibility (e.g., Thornburgh & Rife, 1996), the Opportunities, Barriers, and Implementation Drivers did not commonly mention physical facilities. Instead, Opportunities, Barriers, and Implementation Drivers mostly concerned programs and resources.

Opportunities

Participants described six opportunities for implementing Inclusive Language and Inclusive Learning. While some participants perceived no barriers to implementing content, all participants identified at least one opportunity to implement Inclusive Language and at least one opportunity to implement Inclusive Learning in their congregation. This suggests content in the ROLLING PD was actionably salient to religious leaders as they made ample connections between ROLLNG PD content and needs in their congregation for supporting youth and young adults with disabilities. The most frequently identified opportunity theme was Inclusive Practices, which were practices in the congregation that came directly from ROLLING PD content. Opportunities to implement Inclusive Language encompassed (a) asking youth and young adults with disabilities they wish to be identified, (b) communicating with parents and family members, (c) making accommodations so youth and young adults with disabilities can participate in activities, and (d) being mindful of the requirements of activities and how youth and young adults with disabilities can participate. Each of these practices fulfill practices parents

raising youth with IDD believed would be helpful to their child or their family in their congregation (Ault et al., 2013a, Ault et al., 2013b; Carter, Boehm, et al., 2016).

Participants identified Advocacy as an opportunity to implement Inclusive Language and Inclusive Learning. This opportunity may be especially salient to relieve the burden of parents, who report having to advocate for their child with IDD in their congregation (Richardson & Stoneman, 2015). Leaders' increased knowledge and confidence may also support them in taking on the role of advocate within their congregation.

Leaders also identified opportunities to communicate their newfound knowledge with other leaders, such as their congregation or ministry leadership team, staff members, or other clergy members. These opportunities illustrate that training is most likely needed for several stakeholders in the congregation to implement Inclusive Language and Inclusive Learning. More interventions with non-clergy leaders may be needed, such as the program described in Baggerman et al. (2015), where a Sunday school teacher learned to implement classroom management strategies to support youth with disabilities. In describing opportunities to share with other leaders, participants named stakeholders who worked directly with youth (e.g., Sunday school teachers) as well stakeholders who did not work directly with youth (e.g., church council). Thus, while targeted training for direct support personnel (e.g., youth director, clergy) may be effective at improving their capacity to support youth and young adults with disabilities, leaders themselves may take a more global view in communicating the need for this training.

Barriers

Additionally, participants conveyed five barriers they perceived to implementing Inclusive Language and Inclusive Learning. Barriers identified by participants echo those identified by parents of youth with IDD and religious leaders. Parents shared the need for more

resources, knowledgeable leaders, and welcoming attitudes toward youth and young adults with IDD (e.g., Ault et al., 2013; Carter, Boehm, et al., 2016; Jacober, 2010; Pearson et al., 2021), while religious leaders previously communicated feeling unable to better support youth with IDD (e.g., Patka & McDonald, 2015). Leaders most often cited insufficient resources as a barrier, which included the desire for more human capital, facilities, and funding. However, barriers of perception (i.e., "avoidance/stuck," "unintended bias," "resistance") were cited more often, echoing the continuing need for "attitudinal accessibility" (Trealor, 2000, p. 12). Of note is that leaders often perceived their congregation-at-large as holding attitudes that served as barriers to implementing Inclusive Language and Inclusive Learning. Barriers identified by participants further add specificity to the longstanding claim that changes in tangible congregational resources such as training, personnel, and facilities must accompany changes in congregational attitudes (Carter, 2020; Thornburgh & Rife, 1992; Treloar, 2000).

Implementation Drivers

Last, participants communicated seven drivers they believed helped them implement Inclusive Language or Inclusive Learning. As with barriers, tangible drivers (e.g., Pesources, Personnel) were named alongside intangible drivers (e.g., Values, Awareness, Accountability). Together, the drivers identified provide exemplars of factors religious congregation leaders may consider in increasing support for youth and young adults with IDD. Within Implementation Drivers, participants frequently named efforts from multiple stakeholders within the congregation (including the congregation-at-large) as necessary for removing barriers and implementing Inclusive Language and Inclusive Learning (e.g., religious education teachers, church council members, fellow clergy/staff members). Some Implementation Drivers concerned the capacity or actions of the leader, such as taking time to plan or intentionally initiate

communication with a child with autism. However, the majority of identified Implementation Drivers were factors outside the leader's direct control (e.g., facility changes, agreement from board members). Leaders frequently communicated the importance of having agreement or prioritization from multiple individuals. This notion reflects a common perception that institutions, and religious institutions in particular, often demonstrate a slow pace of change which can obstruct accessibility, inclusion, and belonging efforts (Thornburgh & Rife, 1996). Previously, parents raising children with disabilities conveyed their congregation sometimes did not respond to the needs of their family (Jacober, 2010; Pearson, Stewart-Ginsburg, et al., 2021; Richardson & Stoneman, 2015). Leaders in this study confirmed previous suppositions that increasing support and belonging for youth and young adults with disabilities in congregations requires a multifaceted approach contingent upon several intrapersonal and interpersonal factors (Carter, Boehm et al., 2016; Carter et al., 2017; Taylor et al., 2014).

5.3 RQ3: How do religious congregation leaders perceive the ROLLING PD training?

Across studies, religious leaders conveyed their awareness of being insufficiently prepared to support youth and young adults with disabilities (Baggerman et al., 2015; Francis & Jones, 2015; Patka & McDonald, 2015; Stewart-Ginsburg et al., 2020, 2021). However, direct consumers (i.e., religious leaders) must have a favorable perception of the goals, processes, and outcomes of the training in order to find it meaningful (Patka & McDonald, 2015; Schwartz & Baer, 1991) and implement strategies offered in the training (Bertram et al., 2014). Most participants who completed the ROLLING PD agreed or strongly agreed the training was acceptable, appropriate, effective, and implementable. These data suggest participants held a favorable view of the goals, processes, and outcomes of the ROLLING PD. Qualitatively, participants also offered specific points of feedback and suggestions regarding ROLLING PD

content. The study also provides initial evidence that characteristics of Inclusion in General Education is a socially valid framework to use in providing training to religious congregation leaders on supporting youth and young adults with disabilities.

5.4 Contributions to the Literature

The ROLLING PD improved participants knowledge and confidence implementing Inclusive Language and Inclusive Learning. All participants identified opportunities to implement Inclusive Language and Inclusive Learning within their congregation. In addition, participants appraised the intervention as effective and relevant. This suggests explicit instruction on Inclusive Language and Learning with embedded examples will help participants identify ways they can put these ideas into practice and, in doing so, increase their congregation's support for youth and young adults with disabilities. However, almost all participants still identified intrapersonal or interpersonal barriers that would stop or limit their implementation of Inclusive Language or Inclusive Learning. Some barriers were structural (e.g., the order of worship) while others were relational (e.g., congregation members resisting change). This suggests that while explicit training for leaders can be an effective way to address early stages of exploration and adoption (e.g., knowledge, confidence, opportunities to implement new ideas; Bertram et al., 2014), training alone will not remove barriers youth with IDD experiencing participating in congregations. Participants conveyed that resistance to change, unintended bias, and resource and personnel limitations may still prevent leaders from enacting their identified opportunities. Implementing structural change within formal organizations is a multifaceted effort that requires increased leadership capability, organizational capacity, and competency (Bertram et al., 2014). While training and subsequent increases in knowledge, confidence, and perceived opportunities

assist in exploration, more supports are needed in order to remove barriers and make lasting change.

A second major contribution is the role of all leaders within a religious congregation in implementing Inclusive Language and Inclusive Learning. At least one theme emerged within each area of implementation (i.e., Opportunities, Barriers, Drivers) that concerned other leaders. While this training focused specifically on formal leaders (i.e., clergy, staff members), leaders described the necessity of other leaders joining them in making changes to support youth and young adults with disabilities. Fourteen responses described opportunities to share resources and ideas with other leaders in the congregation (e.g., religious education colleagues, education committee). Within the barrier of Resources, participants described how attitudes from other staff and volunteer leaders (e.g., church council, senior minister) may inhibit implementation. Last, and perhaps most telling, leaders most often described needing the support or agreement of leaders and colleagues (e.g., "buy-in") as a factor to implement Inclusive Language and Inclusive Learning. This is consistent with the Distributed Leadership Model (Harris, 2004) which posits that influence to make change is distributed throughout an organization and held by multiple stakeholders. Religious congregations require multiple stakeholders wielding influence to fulfill their mission (Clerkin & Swiss, 2013). This is why prior studies on supporting youth and young adults with disabilities in congregations involved parents (e.g., Carter & Boehm, 2019), clergy (e.g., Patka & MacDonald, 2015), staff members (e.g., Stewart-Ginsburg et al., 2020), and volunteers (e.g., Baggerman et al., 2015).

Similarly, religious leaders frequently described the need for training, awareness, and support to extend to the entire congregation. Within Opportunities, participants described communicating the necessity of Inclusive Language and Inclusive Learning with their

congregation. In barriers, themes of Resistance and Avoidance usually concerned the congregation at large. In total, these ideas convey the importance of the entire congregation understanding and embracing changes to better support youth and young adults with disabilities. This idea is consistent with findings of Carter et al., (2017), who found that many suggestions made by congregation members and leaders to better include youth and young adults with disabilities involved the interest and support of congregation members.

Last, while the ROLLING lessons trained leaders on strategies validated for youth and young adults with disabilities, leaders communicated opportunities, barriers, and drivers in the congregation to support people with disabilities across the lifespan (i.e., children, youth, adults). This may reflect the varied responsibilities of participants (e.g., 51.7% held responsibilities in addition to or outside of direct service with youth/young adults) or that congregation leaders are aware of the need to increase support for people with disabilities at all life stages (e.g., children; Richardson & Stoneman, 2015; youth; Ault et al., 2013; adults; Jacober, 2010; cf. Stewart-Ginsburg et al., 2020). More likely, this reflects the mission of religious congregations to support people throughout the lifespan (Avent et al., 2015; Carter, 2020). While training on strategies to support a specific age group may be relevant in specific situations (e.g., Sunday school, youth group, adult religious education), leaders appear to conceptualize more global change in congregations to support people with disabilities at all ages.

5.5 Limitations

Several limitations for this study exist. These will be described in measures, participants, and study goals. First, the knowledge questionnaire was a researcher-created instrument that was not previously validated and had unknown reliability. Further, following instrument guidelines (i.e., Williams & Deci, 1996), I measured overall confidence as the average of four individual

items (i.e., possible score of 7) rather than a sum of the four individual confidence items (i.e., possible score of 28). Effects of the ROLLING PD may be stronger for one specific domain of confidence (e.g., confidence implementing Inclusive Language versus Inclusive Learning). High confidence in one domain (e.g., Inclusive Language) may skew overall confidence and hide lower confidence in other domains (e.g., Inclusive Learning; Williams et al., 2004). I also did not measure impacts of the training on individual confidence domains. The training may be more effective improving the confidence implementing Inclusive Learning than Inclusive Learning, or vice versa.

A limitation exists with the participant sample. Participants represented a majority-White background (81.7%). The goals and objectives of the ROLLING PD and research study were constructed by a White researcher (i.e., me). This, combined with the majority-White sample, presents a risk of cultural bias (Trainor, 2017). I attempted to limit this bias by (a) incorporating video content featuring presenters from culturally diverse backgrounds; (b) recruiting presenters from culturally diverse backgrounds to create lesson content; (c) featuring graphics and examples in the presentation that identifiably featured diverse religious congregations; and (d) inviting researchers from culturally diverse backgrounds to serve on qualitative coding team. Participant performance was not significantly different for participants of color. However, the relatively culturally-homogenous sample results should be interpreted with caution in drawing conclusions about (a) the cultural responsiveness of the ROLLING PD and (b) the effects of the ROLLIND PD for leaders of color. Religious leaders in historically marginalized communities conveyed additional expectations their community placed on them (e.g., parenting advice; Avent, 2015). The ROLLING PD may not address these unique contexts or expectations.

The study featured 18.7% attrition with a group differential attrition of 11.7 percentage points between the treatment and control groups. The differential attrition increases threats to internal validity and does not meet the boundary for optimistic assumptions of low attrition (What Works Clearinghouse, 2020). The study took place during the COVID-19 pandemic. While the pandemic did not disrupt data collection, participants who responded to reminders to complete study tasks anecdotally cited professional constraints associated with the COVID-19 pandemic as a reason for incompletion of tasks. This is consistent with broader effects of the COVID-19 pandemic on religious leaders (e.g., Barna Group, 2020; Village & Francis, 2021).

Quantitative analysis measured the knowledge and confidence of religious leaders implementing Inclusive Language and Inclusive Learning. Qualitative analysis characterized the opportunities, barriers, and drivers for implementing. All of these factors are categorized as preliminary steps of implementation (Bertram et al., 2014). Therefore, it is unknown if an increase in knowledge and confidence will lead to actual implementation of principles of Inclusive Language or Inclusive Learning. Outcomes measured in the study are important constructs for initial implementation, but they do not in and of themselves lead to increasing inclusion, participation, and belonging for youth and young adults with IDD in religious congregations (Bertram et al., 2014; Carter, 2020).

Participants accessed the training over three or four weeks. It is not feasible for leaders or organizations to implement large-scale changes in this brief timeline given (Bertram et al., 2014). Lasting implementation of new strategies requires (a) exploration, (b) installation, (c) initial implementation, and (b) full implementation, which is a process that usually takes a minimum of two to four years (Bertram et al., 2014). Therefore, the study cannot ascertain whether leaders

will actually implement the opportunities, remove the barriers, or employ the drivers to implementation they identified.

Last, youth- and family-level outcomes were not measured. Several reasons informed this decision. First, limited participation of youth and young adults with IDD in religious congregations made the possibility of recruiting enough actively-participating youth/young adults with IDD and their family members to satisfy sample size estimates improbable (Whitehead, 2018). Second, the goal of the study was to measure the effects of the ROLLING PD on knowledge and confidence rather than implementation itself. In order to initialize exploration (i.e., the first step in implementation), organizations and their leaders need access to effective training designed to improve their capacity to enact change (e.g., knowledge, confidence; Bertram et al., 2014). Religious leaders communicated a perceived dearth of training methods on supporting youth and young adults with disabilities in religious congregations (Ault, 2010; Patka & McDonald, 2015; Slocum, 2016; Stewart-Ginsburg, 2021). This suggests measuring and establishing the effects of a training method is the first step toward implementation. Because of these reasons, it is unknown whether implementation of either principles of Inclusive Language or Inclusive Learning lead to increased belonging or participation of youth and young adults with disabilities in religious congregations.

5.6 Suggestions for Future Research

Despite these limitations, results and contributions from the study suggest several venues for future research. Suggestions are evident for research both with and beyond this ROLLING PD intervention. Replication of the intervention is necessary to increase external validity and should incorporate a revised ROLLING PD that addresses participant suggestions. Three facets of replication will strengthen the evidence base for the ROLLING PD. First, the ROLLING PD

should be evaluated with a significantly larger population of religious leaders representing culturally-diverse backgrounds to ascertain if effects are maintained across a more diverse sample and within specific cultural backgrounds. In addition to investigating and limiting cultural bias of the ROLLING PD, this suggestion may result in a myriad of new opportunities, barriers, and drivers to implementation identified particularly given the communal prominence of religious congregations in communities of color (Pargament et al., 1998). For example, leaders of Black religious congregations conveyed additional expectations placed upon them as community and religious leaders (Avent et al., 2015). Therefore, future research should determine the effects and salience of trainings that (a) address additional expectations or experiences unique to religious leaders in communities and (b) are with a sample predominantly comprised of religious leaders of color.

Next, future research should include measurements of short- or long-term implementation to determine if and to what extend participants implement any components of Inclusive Language or Inclusive Learning. For example, researchers could partner with religious leaders to (a) identify opportunities for implementing Inclusive Language and Inclusive Learning, (b) generate implementation methods and outcomes, and (c) measure implementation of Inclusive Language and Inclusive Learning in a congregation over a period of two years. Future studies could incorporate a youth- or family-level outcome that measures the short-term or long-term effects of the ROLLING PD on youth or family perceptions of, attendance at, or participation in a religious congregation to determine the effects of the training. Last, future research is necessary to explore the effects of the ROLLING PD on the outcome variables for preservice religious congregation leaders (e.g., students in a seminary or training program). This is especially salient

given the dearth of formal training seminary students receive in this area (Annandale & Carter, 2014).

Additionally, research is warranted to further explore the Predictors of Post-School Success as a framework for providing professional development and increasing participation of youth and young adults with IDD in community organizations. Previously, religious leaders communicated they were unsure of where to find resources or training in supporting youth and young adults with disabilities (Patka & McDonald, 2015; Stewart-Ginsburg et al., 2020, 2021). In this study, leaders appraised the training topics as relevant to their work. This suggests characteristics of the Predictors of Post-School Success may provide a framework for including and supporting youth and young adults with IDD in non-school settings. Future studies may explore the effects of providing explicit instruction on Inclusive Language and Inclusive Learning (Rowe et al., 2015) for other community organization leaders (e.g., social clubs, interest activities; Kohler et al., 2016) or implementing other Predictors of Post-School Success (Mazzotti et al., 2021) in community organizations as a mechanism for increasing participation of youth and young adults with disabilities. Researchers may consider operationalizing the Predictors of Post-School Success within community organizations to develop common language in practices that support youth and young adults with disabilities. Similarly, research is needed to explore and validate programs, processes, and partnerships that religious congregations and leaders use to promote participation and belonging of youth and young adults with disabilities in religious congregations.

5.7 Implications for Policy and Practice

In addition to suggestions for future research, this study provides several implications for policy and practice. These are listed in relation to (a) policy in school agencies, (b) training of

religious congregation leaders, (c) partnership with religious congregations, and (d) praxes in religious congregations.

Policy in School Agencies

Several implications for policy in school agencies should be drawn from this study. First, secondary transition teachers should consider opportunities for religious students to develop skills as they participate in desired activities in their religious congregation (e.g., social skills, financial literacy). As part of the IEP, the study and family members may request the presence of a community member who is familiar with the student to attend the meeting (IDEA, 2004). Religious congregation leaders and members may be well suited to offer expertise on the student, particularly on their strengths and interests (Stewart-Ginsburg & Kwiatek, 2020). At the direction of the student or family, IEP team members should solicit the input and participation of the religious leader in the IEP team for students who consider themselves religious and participate in a religious congregation. Inviting religious leaders to the IEP meeting is one way to promote interagency collaboration, which is encouraged by IDEA (2004; §300.347(b)(2)) and associated with positive employment and education outcomes for youth with disabilities (Carter et al., 2009; Mazzotti et al., 2021; Test, Mazzotti, et al., 2009). As demonstrated in this study, religious leaders can identify opportunities, barriers, and implementation drivers for students with disabilities participating in the religious congregation. Religious leaders may be able to assist IEP team members in identifying opportunities, barriers, and implementation drivers for youth with disabilities within the religious congregation and community to ensure students achieve positive outcomes. This implication can also assist teachers in becoming more culturally responsive by (a) involving trusted community members who possess knowledge of the student and the family and (b) supporting the family's values (Pearson, Hamilton, et al., 2021).

Training of Religious Congregation Leaders

First, training organizations and religious denominations could utilize the ROLLING PD to train in-service religious congregation leaders to support youth and young adults with IDD. Next, seminaries could implement professional development or courses in Inclusive Language and Inclusive Learning as part of their required curriculum (e.g., required completion of the ROLLING PD) to increase the knowledge and confidence of current and future religious leaders to support youth and young adults with disabilities. Seminaries do not often have a codified or required plan to train religious leaders to support people with disabilities (Annandale & Carter, 2014). Incorporating required coursework on Inclusive Language and Inclusive Learning for youth and young adults with disabilities within clergy or religious educator preparation programs may increase the knowledge and confidence of religious leaders to implement these ideas in their current or future congregations. This study demonstrates the effectiveness and social validity of providing direct instruction to religious congregation leaders in strategies to support people with disabilities.

Partnership with Religious Congregations

Secondary transition practitioners may consider how religious congregations can partner with schools to support transition and community involvement for youth and young adults with IDD (e.g., community-based instruction, community service opportunities; Kohler et al., 2016; Stewart-Ginsburg & Kwiatek, 2020). Given the limited research in supporting families in religious settings (Ault, 2010; Slocum, 2016), special education and secondary transition practitioners could provide the lessons as training for leaders in religious congregations to support youth and young adults with disabilities. Education professionals seeking to partner with religious congregations within interagency collaboration models (e.g., CIRCLES; Flowers et al.,

2018) may consider providing training in to religious leaders in Inclusive Language as a means to promote partnership and understanding (Rowe et al., 2015). This is especially important given the lessons on Inclusive Language and Inclusive Communication were identified as favorite lessons by 7 (35%) participants.

Praxes in Religious Congregations

In addition, the study demonstrated the association between explicit training in characteristics of Inclusion in General Education and leader knowledge and confidence implementing characteristics of Inclusion. Therefore, religious congregation leaders should take steps to implement the principles of Inclusive Language and Inclusive Learning in religious congregations. Leaders may find it beneficial to consider the list of opportunities participants identified to implementing these principles (e.g., leadership team meetings, religious education classes) as places to begin implementation to better support youth and young adults with disabilities. In addition, leaders may find it useful to use identified Implementation Drivers as starting points to consider factors present in their congregation to increase support for youth with IDD. In addition, given the consistent listing of the need for all leaders to support youth and young adults with disabilities, religious congregations should prioritize training all leaders on strategies to support people with disabilities (i.e., not only leaders who work directly with youth).

Conclusion

Previous studies suggested providing professional development to community organization leaders (e.g., staff, volunteers) was effective in increasing knowledge and implementation of supportive strategies and behaviors to increase participation of youth with IDD (e.g., Baggerman et al., 2015). Limited intervention research exists in the area of religious congregations supporting youth and young adults with disabilities, specifically IDD (Ault, 2010;

Slocum, 2016). At present, the only identified intervention with this stated purpose is the Tell-Show-Try-Apply coaching package (Baggerman et al., 2015). Therefore, this study contributes to the literature by demonstrating initial effectiveness for one PD package to increase the overall knowledge and confidence of religious leaders on Inclusive Language and Inclusive Learning to support youth and young adults with IDD. As a result of this training, participants in the treatment group identified opportunities for implementation, barriers to implementation, and drivers to implementation. This indicates online asynchronous training may be an appropriate method for training religious leaders to support youth and young adults with IDD. Further, findings suggest ROLLING PD may be a viable, effective way to increase knowledge of and confidence in implementing Inclusive Language and Inclusive Learning within a religious congregation.

This study provides initial evidence to suggest the effectiveness of training on the Predictors of Post-School Success for community and religious congregation leaders. It reflects data that may provide a potential way to remove systemic barriers for participation in these organizations for youth and young adults with IDD (Rowe et al., 2015). Treatment group participants viewed the goals, processes, and outcomes of the training favorably and offered several suggestions for improvement. Further, participants conveyed examples of how the training content was relevant to their work in religious congregations. The ROLLING PD may be one way for congregation leaders to increase knowledge and confidence supporting youth with IDD and, in turn, identify opportunities to implement this knowledge.

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APPENDIX A: ROLLING PD LESSON SCOPE AND EXAMPLES

Lesson	Title	Objectives
Unit 1: Inclusive Language		
Inclusive congregations develop a receptive congregational atmosphere for including students with disabilities in general education by educating administrators, teachers, other staff, and students about person-first language and disability rights (EC 4).		
1	**Inclusive Language**	- Participants will be able to describe models of disability (i.e., medical, social). - Participants will be able to identify examples of person-first and identity-first language. - Participants will be able to describe appropriate circumstances to use person- and identity-first language.
2	**Inclusive Laws**	- Participants will be able to recognize federal laws governing services for individuals with disabilities (i.e., ADA, IDEA). - Participants will understand portions of the ADA that concern houses of worship.
3	**Social Skills**	- Participants will describe the three steps in social skill instruction. - Participants will learn opportunities to teach social skills within the religious congregations.
Unit 2: Inclusive Learning		
Provide professional development for secondary personnel to ensure personnel are qualified to use universal design for learning and evidence-based instructional strategies (EC 7).		
4	**Multiple Means of Representation**	- Participants will understand how to provide multiple means of representation.
5	**Multiple Means of Action and Expression**	- Participants will understand how to provide multiple means of action and expression.
6	**Multiple Means of Engagement**	- Participants will understand how to provide multiple means of engagement.

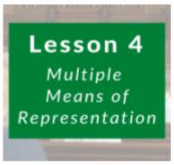
ROLLING PD Lessons

Welcome! Thank you for joining us as we learn **strategies to support people with disabilities** in religious congregations.

This home page serves as your **navigation tool** for all important information, resources, and lessons. As we progress through this course, you will **complete six lessons** (two per week). Lessons for the week will open on Monday and will close on Sunday. You can complete lessons **at any time** throughout the week.

There will be a formal way to provide feedback at the end of the training. Happy learning!

Click on the pictures to access the information/page(s).

 Access materials by **working across rows.**	 **Click on the icons** to go to that page.	 **Need help? Have questions?** Email Jared!
	 Everything you **need to know**! *(Estimated time: 7 minutes)*	 These are the **"pre-test"** tasks. *(Estimated time: 16 minutes)*
		
		
		
	 The final tasks to complete! *(Estimated time: 20 minutes)*	 You made it! Thank you for your time!

APPENDIX B: KNOWLEDGE QUESTIONNAIRE

Lesson	Question 1	Question 2	Question 3
1 (2 pts)	Check all that are examples of person-first language. **Person with autism** Disabled person They are Deaf **He has an intellectual disability**	Check all that are examples of identity-first language **Autistic person** Person with a disability **They are Deaf** They have a hearing impairment	Check all that are examples of appropriate language. Handicapped **Accessible** **Congenital** Birth defect
2 (2 pt)	Which of the following are examples of an accommodation? (Choose two). **A. Providing a child a pencil that is easier to write with.** B. Changing the requirements for a religious rite (e.g., Baptism, B'nai Mitzvah). C. Rewriting membership vows to simplify the language. **D. Changing how someone can respond to the membership vows.**	Which of the following are examples of a modification? (Choose two). A. Providing a child a pencil that is easier to write with. **B. Rewriting membership vows to simplify the language.** C. Changing how someone can respond to the membership vows. **D. Changing Sunday School lesson content.**	Which of the following are examples of an accommodation? (Choose two). A. Changing the requirements for confirmation class. B. **Wearing headphones during the service**. C. **Allowing someone to write a statement of faith instead of reciting it verbally.** D**.** Rewriting a statement of faith to it is easier to recite.
3 (1 pt)	Fill in the blanks: To teach social skills, first we [identify], then we teach, then we review.	Fill in the blank: To teach social skills, first we identify, then we [teach], then we review.	Fill in the blank: To teach social skills, first we identify, then we teach, then we [review].
4 ß∑	Which of the following options of Multiple Means of Representation is the leader providing? *A leader uses pictures to illustrate their sermon as they present it.* A. Perception B. **Language/Symbols** C. Understanding	Which of the following options of Multiple Means of Representation is the leader providing? *Before reading scripture, the leader shows a picture pointing out connections to other scripture stories (e.g., context).* A. Perception B. Language/Symbols	Which of the following options of Multiple Means of Representation is the leader providing? *A leader offers alternatives to reading information.* A. **Perception** B. Language/Symbols C. Understanding

		C. Understanding	
5 (1 pt)	Which of the following options of Multiple Means of Action and Expression is the leader providing? *A leader teaches how to find scripture verses or stories.* A. Physical action B. Expression and communication C. **Executive functions**	Which of the following options of Multiple Means of Action and Expression is the leader providing? *A Sunday School teacher directs their class to move to a corner of the room to answer a question.* A. **Physical action** B. Expression and communication C. Executive functions	Which of the following options of Multiple Means of Action and Expression is the leader providing? *A leader encourages congregants to write or draw prayer requests on cards instead of saying them aloud.* A. Physical action B. **Expression and communication** C. Executive functions
6 (1 pt)	How is the leader providing **Multiple Means of Engagement** in this example? *A leader reviews how everyone can participate in the group meeting before they begin.* A. **Posting expectations** B. Promoting community C. Planning examples	How is the leader providing **Multiple Means of Engagement** in this example? *A teacher encourages students to work in groups to solve a faith-based problem.* A. **Posting expectations** B. Promoting community C. Planning examples	How is the leader providing **Multiple Means of Engagement** in this example? *A leader provides several ways youth could and could not apply the lesson to their life at school and at home.* A. Posting expectations B. Promoting community C. **Planning examples**
Total			/ 8 points

APPENDIX C: PARTICIPANT CONFIDENCE QUESTIONNAIRE

Criteria	1	2	3	4	5	6	7
	Not at all true	Usually not true	Rarely true	Somewhat true	Occasionally True	Usually True	Very true
1. I feel confident in my ability to implement *inclusive language* in a religious congregation.							
2. I feel confident in my ability to implement *inclusive learning* in a religious congregation.							
3. I feel confident in my ability to support individuals with disabilities in religious congregation.							
4. I feel able to meet the challenge of supporting individuals with disabilities in religious congregation.							
Total Score (28 points total)							
Confidence Average (points total / 4)							

Note. Contextualized from the Perceived Confidence Scale (PCS; Williams & Deci, 1996)

APPENDIX D: DIMENSIONS OF BELONGING RATING SCALE

Criteria	**1**	**2**	**3**	**4**	**5**
Please rank your agreement with the following statements:	Rarely	Seldom	Sometimes	Often	Always
1. At my congregation, people with disabilities are *present* (i.e., regularly participating in the congregation).					
2. At my congregation, people with disabilities are *noticed* (i.e., recognized as a familiar face by others).					
3. At my congregation, people with disabilities are *welcomed* (i.e., others extend authentic friendliness, real gestures of hospitality).					
4. At my congregation, people with disabilities are *accepted* (i.e., they are embraced for who they are).					
5. At my congregation, people with disabilities are *supported* (i.e., they are provided with needed assistance or adaptations).					
6. At my congregation, people with disabilities are *cared for* (i.e., their spiritual, emotional, or instrumental needs are addressed).					
7. At my congregation, people with disabilities are *known* (i.e. others are aware of their gifts, strengths, passions, personalities, and needs).					
8. At my congregation, people with disabilities are *befriended* (i.e., they have relationships that extend throughout the week).					
9. At my congregation, people with disabilities are *needed* (i.e., members of a congregation see them as bringing gifts and talents to share that benefit the entire community).					
10. At my congregation, people with disabilities are *loved* (i.e., being and feeling loved by others within one's faith community).					
Total score (70 points total)					

Note. Dimensions of Belonging (Carter, Biggs, et al., 2016).

Participants assigned to the ROLLING condition will complete this section during the posttest:

Did your rating on any of these change form when you took it before the lessons? If so, please explain any changes you made in the way you rated your congregation after completing the ROLLING lessons.

APPENDIX E: SOCIAL VALIDITY QUESTIONNAIRE

Criteria	1	2	3	4	5	6
	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
Overall training						
1. The ROLLING training is acceptable for my religious organization.						
2. Most religious leaders will find the ROLLING training appropriate.						
3. The ROLLING training should prove effective in meeting the stated purpose of training religious leaders to support youth and young adults with disabilities.						
4. I would suggest this ROLLING training to other religious leaders.						
5. The ROLLING training is appropriate to meet the congregation's needs and mission.						
Strategies and predictors						
6. I would be willing to use these strategies in this congregation.						
7. This primary plan will not result in negative side effects for persons.						
8. These strategies are appropriate for a variety of children,						

youth, and/or young adults.						
Timing and engagement						
9. The ROLLING training lessons took me an appropriate length of time to complete.						
10. I looked forward to completing the training lessons.						
Congregational inclusion						
11. Strategies address in this training will help our congregations support belonging for people with disabilities.						
12. Strategies addressed in this training will help other congregations increase belonging for people with disabilities.						
Total Score (66 points total)						
Open-ended questions						
13. What do you feel is most beneficial about the ROLLING training?						
a. What is the least beneficial part?						
14. Do you think your participation in the ROLLING training will cause your congregation's capacity to support individuals with						

disabilities to improve?	
a. Why or why not?	
15. What would you change about this plan (components, design, etc.) to make it more leader-friendly or relevant?	
16. What topics were *not* covered that you would like to learn about?	
17. What other information would you like to contribute about this plan?	

Note. Adapted from Primary Intervention Rating Scale (PIRS; Lane et al., 2009) and Dimensions of Belonging (Carter, Biggs, et al., 2016).

APPENDIX F: PROCEDURAL FIDELITY CHECKLIST

Date:	Participant:	Times started and completed:	

Checklist completed by:			
Step:	BAU	PD	Date
1. Researcher ensures proper functioning of the Canvas training system.			
2. Participant accepts invitation to online course by creating account.			
3. Participant completes demographic form.			
4. Participant is matched to another participant.			
5. Participant is randomly assigned to (circle): ROLLING BAU			
6. Participant completes Knowledge pretest.			
7. Participant completes Confidence pretest.			
8. Participant completes Dimensions of Belonging rating pretest.			
BAU Condition			
9. Participant does not access to ROLLING PD.			
ROLLING Condition			
10. Participant completes Introduction Lesson.			
11. Participant completes Lesson 1.			
12. Participant completes Lesson 2.			
13. Participant completes Lesson 3.			
14. Participant completes Unit 1 Implementation Questionnaire.			
15. Participant completes Lesson 4.			
16. Participant completes Lesson 5.			
17. Participant completes Lesson 6.			
18. Participant completes Unit 2 Implementation Questionnaire.			
19. Participant completes social validity questionnaire.			
20. Participant completes final Implementation Questionnaire.			
ALL Participants			
21. Participant completes Knowledge posttest.			
22. Participant completes Confidence posttest.			
23. Participant completes Dimensions of Belonging rating posttest.			
Total			
	÷ 12	÷ 22	
	%	%	

Notes:

APPENDIX G: RECRUITMENT MATERIALS

Email Recruitment Letter

Dear [Salutation],

First, I hope you are staying safe and healthy in this difficult season.

I am writing to see if you would be interested in completing an online pilot training program over the next few weeks on supporting youth with disabilities in religious congregations. I am a PhD candidate in Special Education at UNC Charlotte; my work involves finding and sharing ways to help clergy and religious leaders support folks with disabilities. I was a teacher and religious education director before returning to school to study this and find effective ways to train religious leaders.

I realize this is just about the worst time imaginable to ask you to add something to your plate. But if on the off chance you were interested in training in this area, I would love to invite you to participate.

If it's a bad time, then please let me know if there are other ways (now or in the future) that I could support you in this area. This area is my life's work and I would be honored to help you. **If you know someone** who might be interested in participating, please feel free to forward this email to them.

If you might be interested, here are the details:

- The purpose of the study is to pilot a training program for religious leaders implementing strategies to support youth and young adults with disabilities. I hope you will find the training useful, and I will welcome suggestions for how it can be improved.
- We are asking religious leaders to participate who either (a) serve as clergy members at a religious congregation or (b) serve as staff members responsible for religious education for youth (i.e., 14-21 years old). You do not have to have any experience or training in this area to participate. If you have formal training in this area (e.g., you were a special education major in college), we'd love to ask you to forward this to a colleague who might find it useful.
- The time commitment involves five weeks of your time. You will be randomly assigned to either the training group or the assessment group.
    - Participants in the training group will complete three weeks of lessons (two lessons per week; about two hours per week).
    - Participants in the assessment group will not complete the training.
    - We will ask both groups to complete short tasks before and after the training group completes the training.
    - After the study finishes, we will give participants in the assessment group the chance to complete the training on their own time.

- The training delivery is asynchronous online. That means all of the lessons and materials will be accessed online. You can complete the lessons at any time you wish throughout the week.
- We will offer participant a gift card to Amazon or Starbucks in gratitude for your participation. Regardless of what you think of the training, you will receive the gift card if you complete all parts of the study.

If you are interested or you have questions, please reply to this email. I'd love to talk with you. Either way, we appreciate your time in reading this email and we wish you courage and rest for the days ahead.

Many thanks,

Jared Stewart-Ginsburg
Doctoral Candidate
Department of Special Education
and Child Development
Cato College of Education
University of North Carolina at Charlotte
(980) 349-8525
jginsbur@uncc.edu

Valerie Mazzotti, PhD
Faculty Advisor
Department of Special Education
and Child Development
Cato College of Education
University of North Carolina at Charlotte
(704) 687-8828
vlmazzot@uncc.edu

Email Follow-up Script

Hi, [Salutation]!

I hope your week is going well. I'm following up on an email I sent on [date] seeing if you'd like to participate in an online training to support youth and young adults with disabilities in religious congregations. If you were interested, I'd love to hear from you! Feel free to reply to this email with any questions you might have.

If the email got lost in cyberspace, here are some details: The purpose of the study is to pilot a training program for religious leaders implementing strategies to support youth and young adults with disabilities. I hope you will find the training useful, and I will welcome suggestions for how it can be improved.

- We are asking religious leaders to participate who either (a) serve as clergy members at a religious congregation or (b) serve as staff members responsible for religious education for youth (i.e., 14-21 years old). You do not have to have any experience or training in this area to participate. If you have formal training in this area (e.g., you were a special education major in college), we'd love to ask you to forward this to a colleague who might find it useful.
- The time commitment involves five weeks, and you can expect to spend no more than two hours per week participating.
- The training medium is asynchronous online. That means all of the lessons and materials will be accessed online. You can complete the lessons at any time you wish throughout the week.
- We will offer participant a gift card to Amazon or Starbucks in gratitude for your participation. Regardless of what you think of the training, you will receive the gift card if you complete all parts of the study.

I hope to hear from you soon!

Many thanks,

Jared Stewart-Ginsburg
Doctoral Candidate
Department of Special Education
and Child Development
Cato College of Education
University of North Carolina at Charlotte
(980) 349-8525
jginsbur@uncc.edu

Valerie Mazzotti, PhD
Faculty Advisor
Department of Special Education
and Child Development
Cato College of Education
University of North Carolina at Charlotte
(704) 687-8828
vlmazzot@uncc.edu

Telephone Follow-up Script

Hi, there! Is this [name]?

[If no] May I leave a message for them?

[If yes] My name is Jared; I'm calling to follow up on an email I sent you [date] to see if you'd be interested in receiving training on supporting youth and young adults with disabilities through an online study. Is this a good time to talk?

[If no] Totally understand! Is there a better time when you'd have just a moment to talk it through?

[If yes] I know it's a busy time, so have you had a chance to read this email?

[If yes] Do you have any questions after reading this email?

[If yes] I'd love to hear them!

[If no] Would you be willing to consider participating?

[If no] Do you happen to know anyone who might be interested in the training?

[If yes] Awesome! The first step is to get you in the system. What is the best email address to use? [End of script]

[If no] I totally understand! The purpose of the study is to pilot a training program for religious leaders implementing strategies to support youth and young adults with disabilities. I hope you will find the training useful, and I will welcome suggestions for how it can be improved.

We are asking religious leaders to participate who either (a) serve as clergy members at a religious congregation or (b) serve as staff members responsible for religious education for youth (i.e., 14-21 years old). You do not have to have any experience or training in this area to participate.

The time commitment involves five weeks of lessons of about two hours per week. We will ask you to complete short tasks about before and after the training.

The training medium is asynchronous online. That means all of the lessons and materials will be accessed online. You can complete the lessons at any time you wish throughout the week.

We will offer participant a gift card to Amazon or Starbucks in gratitude for your participation. Regardless of what you think of the training, you will receive the gift card if you complete all parts of the study.

[After reading] Do you have any questions I could answer for you?

[If no] So after hearing about it, would you be interested in participating?

[If no] Do you happen to know anyone who might be interested in the training?
[If yes] Wonderful. What is their email?

[If yes] Awesome! The first step is to get you in the system. What is the best email address to use? [End of script]

Social Media Script

Hi, friends!

Putting out the Bat Signal for faith leaders (clergy, staff, etc.). I am working on my PhD dissertation, and I'd love to have you join me for a five-week online pilot training program starting January on supporting youth and young adults with disabilities in congregations. I realize this is just about the worst time imaginable to ask you to add something to your plate. But if you are interested in the training, I would love for you to join me. The training is all online and asynchronous, so you can complete it on your own time (all at once or a little bit at a time). Plus, all participants will receive a gift card! You don't have to currently work with youth or young adults with a disability. If you're interested, feel free to comment below or email me (jginsbur@uncc.edu) and I can share more details. Please feel free to pass this on to other faith leaders you know.

APPENDIX H: INFORMED CONSENT PROCESS

Consent to Participation in Pilot of Asynchronous Online Training of Religious Organization Leaders on Predictors of Post-School Success

Introduction

The Department of Special Education and Child Development at the University of North Carolina at Charlotte supports the practice of protection for human subjects we refer to as research participants. The following information is provided for you to decide whether you wish to participate in the present study. You may refuse to sign this form and not participate in this study. You should be aware that even if you agree to participate, you are free to withdraw at any time. If you do withdraw from this study, it will not affect your relationship with your school system or the unit providing training, the services it may provide to you, or the University of North Carolina at Charlotte.

Purpose

The purpose of this study is to evaluate the effects of an asynchronous online training for religious organization leaders on knowledge of and confidence implementing predictors of post-school success for youth and young adults with disabilities. You are being asked to participate in an online training.

Important Information You Need to Know

- If you choose to participate in the study, you will be randomly assigned to either the training group or the assessment group.
    - Participants in the training group will complete three weeks of lessons (two lessons per week; about two hours per week).
    - Participants in the assessment group will not complete the training.
    - We will ask both groups to complete short tasks before and after the training group completes the training (approximately 15 minutes per session).
    - After the study finishes, we will give participants in the assessment group the chance to complete the training on their own time.
- The lessons will be delivered through an online learning system. You may complete the lessons at a time and location suitable to you.
- You will complete questionnaires before and after completing the study. These questionnaires will ask you to rate your knowledge and confidence on the subject material.
- There are no risks to participating in the study.
- Information gathered from the study can help guide training of religious organization leaders.
- After completing the entire study you will receive a gift card to Amazon or Starbucks. This incentive is not contingent upon your performance in the study.
    - Participants assigned to the assessment group will receive a gift card in the amount of $30.

    - Participants assigned to the training group will receive a gift card in the amount of $60.
- Your decision to take part in this research is completely voluntary. You may refuse, and if you agree to take part you can stop anytime. If you decide not to participate or choose to stop, you will not be penalized in any way. Information gathered during this study will be kept confidential. At no time will your identity be revealed. If any participants experience any discomfort with assessment conditions, participation will be discontinued. The content of modules, questionnaires, and answers given are confidential; please do not discuss them with outside parties.

Please read this form and ask any questions you may have before you decide whether to participate in this research study.

How will my information be protected?

We plan to publish the results of this study. To protect your privacy, we will not include any information that could identify you. After survey incentives are distributed, all email communications between the research team and participants will be deleted.

How will my information be used after the study is over?

After this study is complete, study data will be needed as part of publishing our results. The data we share will NOT include information that could identify you. After this study is complete, identifiers will be removed from the data/information, and the data/information could be used for future research studies or distributed to another investigator for future research studies without additional consent.

What are my rights if I take part in this study?
It is up to you to decide to be in this research study. Participating in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time. You do not have to answer any questions you do not want to answer.

If you choose to withdraw from the study, please contact the principal investigator so that your responses can be removed.

Who can answer my questions about this study and my rights as a participant?
For questions about this research, you may contact Jared Stewart-Ginsburg at jginsbur@uncc.edu or 704-687-5751, or Dr. Valerie Mazzotti, vlmazzot@uncc.edu.

If you have questions about your rights as a research participant, or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the Office of Research Compliance at 704-687-1871 or uncc-irb@uncc.edu.

Consent to Participate

I have read the information above (or have had it read to me), I am at least 18 years of age (or legally emancipated), and I agree to participate in this research project. My choice to participate indicates that I have had the opportunity to ask questions about this study and my participation, and that my questions have been answered to my satisfaction; that I have decided to participate; and, that I have received a copy of this form for my records.

By typing your name, you are providing your digital signature and agreeing to be in this study. Make sure you understand what the study is about before you sign. You will receive a copy of this document for your records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I understand what the study is about and my questions so far have been answered. I agree to take part in this study.

_____ ____/____/_____

Signature Date