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Serving clients with developmental disabilities in clinical practice: utilizing a universal design framework

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ABSTRACT

People with intellectual and developmental disabilities (IDD) are an underserved population in the mental health field. People with IDD are less likely to receive mental health services compared to the general population. Additionally, many social workers lack confidence in serving this population. Universal design is an approach that can enhance social workers' ability to serve diverse populations, including clients with IDD. This article provides recommendations for a universal design for learning (UDL) framework for clinical practice. UDL creates a welcoming and accessible approach for people with IDD, and promotes the development of therapeutic alliances and engagement in the therapeutic process.

KEYWORDS

Universal Design; disabilities; therapy; mental health; social work

Introduction

People with intellectual and developmental disabilities (IDD) are an underserved population in the field of mental health (Weise, Fisher, & Trollor, 2017; Whittle, Fisher, Reppermund, Lenroot, & Trollor, 2018). While people with IDD have similar or higher rates of mental health conditions than people without IDD (Adams & Matson, 2015; Fletcher, Barnhill, & Cooper, 2017), they are less likely to receive services (Whittle et al., 2018). There are many reasons for the disparities in mental health service access faced by people with IDD, one of which is that mental health professionals lack confidence in serving this population (Hinde & Mason, 2020; Maddox et al., 2020; Werner & Stawski, 2012).

Historically, mental health conditions have been overlooked and underdiagnosed in people with IDD as symptoms have been falsely attributed to disability-related behaviors, a concept known as diagnostic overshadowing (Reiss, Levitan, & Szyszko, 1982). In fact, only since the 1980′s has the notion existed that people with IDD could have a mental health diagnosis (Bradley, Hiersteiner, Maloney, Vegas, & Bourne, 2019). The social work profession has taken action to rectify

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historical missteps in serving this population and has worked to decrease disparities in mental health service access. In 2001, the CSWE EPAS (CSWE Educational Policy and Accredidation Standards) mandated inclusion of disability content in bachelor of social work (BSW) and master of social work (MSW) programs. Between 2001 and 2012, social work schools reported a 53% increase in disability content included in the curriculum (Bean & Krcek, 2012). Even so, there continues to be little disability content in MSW curricula, and even less specifically related to IDD (Bean & Kreck, 2012; Fuld, 2020; Laws, Parish, Scheyett, & Egan, 2010). Additionally, few MSW students (1.8%) have field placements related to the IDD population (Council on Social Work Education, 2015). Unsurprisingly, many social workers have low confidence or feel underprepared to serve this population (Bean & Hedgepath, 2014; Dinecola & Lemieux, 2015; Fuld, 2020; Keesler, 2021; Laws et al., 2010). Likely as a result of lack of confidence, specialist services are often recommended for people with IDD who have co-occurring mental health conditions (Venville, Sawyer, Long, Edwards, & Hair, 2015). However, specialized services can lead to increased stigma, do not support social inclusion, and do not promote providers' competence in mainstream mental health services (Scior & Longo, 2005; Venville et al., 2015). Bouras and Holt (2004) explained that advocates for the normalization of disability have argued that specialized services lead to stigmatization by way of increasing opportunities for labeling those with disabilities as "other" and contributing to negative professional attitudes toward this population. Further, some authors have argued that relegating people with IDD to specialist services denies them treatment opportunities available to the general public and furthers the disconnect from their communities (e.g; Corbett, 1991). Still other resources have recommended that the role of providers of specialist services switch to less of a direct care role and more of a place as a facilitators to make mainstream care more accessible and appropriate (DoH, 2001). As a profession, social workers are ethically obligated to strive to serve all populations (NASW, 2017), and the National Association of Social Workers [NASW] proposes that fully integrated, comprehensive services should be made available to all who experience mental health conditions (NASW, 2018).

To meet these ethical obligations, the authors of this paper aim to provide a universal design framework for clinical practice. Universal design (UD) is an approach to therapy that can enhance ability to serve clients with IDD. While UD is usually discussed in reference to classroom learning, physical environment, and rehabilitation, UD applies to clinical practice as well and can be used as a theoretical approach to working with all clients.

What is universal design?

Universal design is a human-centered approach that aims to maximize access to environments and services. Coined by Ron Mace at North Carolina State University in the 1980s, the idea of UD has evolved, and its application across settings and specializations continues to expand. Mace's original 1985 definition is still widely used and describes "the design of products and environments to be useable by all people to the greatest extent possible, without the need for adaptation or specialized design." Other definitions of UD have evolved as they relate to its applications. For example, Chisholm and May (2008) define UD from a web application perspective, "designing for everyone will help to create content that more people can use in more situations." Steinfeld and Maisel (2012) provide an expanded and more comprehensive definition, "Universal design is a process that enables and empowers a diverse population by improving human performance, health and wellness, and social participation." The seven principles of UD relate to the usability and adaptability of a product or service, and speak to applicability: equitable use, flexibility in use, simple and intuitive use, perceptible information, tolerance of error, low physical effort, and appropriate size and space (Steinfeld & Maisel, 2012).

Universal design for learning

Universal Design for Learning (UDL) emerged from the application of Mace's original UD vision to an educational framework. UDL is a set of proactive principles for optimizing learning for all learners, including those with disabilities. This includes providing multiple means of engagement, representation, and action/expression of content (Center for Applied Special Technology [CAST], 2018), enabling learners to interact with and show mastery of information in a variety of ways. In the classroom, examples of using UDL might include presenting a course concept in multiple ways, such as through providing not only lecture materials, but worksheets, videos, and hands-on experiments as well. Or, a teacher might offer a student several choices as to which way they would like to demonstrate their learning (option for audio, video, or multimedia assignments in addition to traditional tests) (Kennette & Wilson, 2019). UDL has become an increasingly popular concept and is included as an instructional strategy in the U.S. Every Student Succeeds Act (2015) and Strengthening Career and Technical Education for the 21st Century Act (2018).

Universal design and social work

Few social work scholars have written on the subject of UD. (Lightfoot & Gibson's 2005) article discusses the use of UDL in social work education, while Burgstahler and Russo-Gleicher (2015) explain how UD strategies in postsecondary environments improve classrooms for students with autism spectrum disorder and all students. Mackelprang and Clute (2009) discuss UD in regards to work environments and employment for people with disabilities. More recently, Kattari, Lavery, and Hasche (2017) discuss UD more broadly, explaining that social workers can use UD principles to improve environments, housing, public transportation, practices, and resources to better serve people with disabilities across the lifespan.

To this point, there has been little discussion in social work of UD applied to clinical practice. However, literature is emerging in this area from scholars in other mental health disciplines. Blando and Lawton (2013) lay the foundation for a Universal Design in Counseling framework, providing practical tips for using UD with an aging population. In 2017, Reid et al. applied a UDL framework to cognitive behavior therapy to improve effectiveness with youth. Of particular relevance during the COVID-19 pandemic is the work of Sheehan and Hassiotis (2017) and Yogarajah, Kenter, Lamo, Kaldo, and Nordgreen (2020) regarding UD and telemental health services. As these authors point out, a UD approach improves telehealth not just for people with IDD but for many service users, including those with low literacy, little technical knowledge, or other disabilities.

Despite the social work profession's lack of scholarly attention to UD, there is a focus on UD concepts in the most recent version of the NASW Standards and Indicators for Cultural Competence in Social Work Practice (2015). New indicators for Standard 9, "Language and Communication," instruct social workers to (NASW, 2015):

- provide and advocate for written and oral information, referrals, and services in the person's preferred language,
- provide jargon-free, easy-to-read materials,
- use descriptive and graphic representations (for example, pictures, symbol formats) for people with LEP (limited English proficiency) or with limited literacy,
- check to ensure accurate communication, realizing that there can be significant variations of word usage and colloquialisms within the same language family based on nationality or region.

Universal design in clinical practice

The updated NASW Standards set the stage for an adoption of a UDL framework for clinical practice. The incorporation of UDL into clinical practice also has important legal implications. Anti-discrimination protections are provided to people with disabilities through legislation including the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and the Affordable Care Act. These laws put in place protections, including reasonable accommodations, to ensure access to health care, public business and organizations, and employment. Accommodations are modifications or adjustments that provide access for people with disabilities (Employer Assistance and Resource Network on Disability Inclusion, 2019). A UDL approach to clinical practice helps to avoid the need for adapting and creating accommodations at a later point, and may completely eliminate the need for individual accommodations (Sheppard-Jones et al., 2021). A UDL approach to clinical practice ensures there are a variety of means for engaging clients in the therapeutic process, a variety of ways of presenting information, and a variety of ways available for clients to express information. Below, we provide recommendations for a UDL clinical practice framework, based on CAST's (Center for Applied Special Technology) UDL principles (2018). CAST's guidelines focus on Providing Multiple Means of Engagement, Providing Multiple Means of Representation, and Providing Multiple Means of Action and Expression. These guidelines are further broken down into suggestions for recruiting interest, sustaining effort and persistence, and other categories. The recommendations below are structured to follow CAST's guidelines.

Provide multiple means of engagement

Clinicians must consider the multiple and diverse ways clients can best be encouraged to engage in therapy. UDL guidelines for providing multiple means of engagement include 1) recruiting interest, 2) sustaining effort and persistence, and 3) self-regulation (CAST, 2018).

Recruiting interest

Recruiting interest in therapy can be done by optimizing individual choice and autonomy, optimizing relevance, value, and authenticity, and minimizing threats and distractions (CAST, 2018). Historically, people with IDD and other marginalized populations have been denied self-determination and their interests and goals were not respected. Still today, people with IDD are often not given a choice in when, or how long they see a clinician or who they see (Whittle et al., 2018). In many cases, a family member or staff person may have their own goals in mind for therapy. However, therapy goals must center

around the client. Social workers can help the client identify and understand why they are in therapy. For example, if the client is not the one who initiated therapy, the social worker can help them identify therapeutic goals by asking them clarifying questions on struggles they may be experiencing or utilizing solution-focused brief therapy techniques like asking a "miracle question" to help them envision the future they desire (Roeden, Maaskant, Bannink, & Curfs, 2011).

When considering how to minimize distractions during therapy, it is important to design the therapeutic environment to reduce sensory overload. Some clients, such as those with autism and those with PTSD, may be susceptible to environmental elements that overstimulate their senses (Legg, 2020). Creating an atmosphere that minimizes sensory overload can be accomplished by lowering the noise level or playing calming music or white noise, choosing neutral paint and design colors, avoiding bright lights, flickering lights, or humming fluorescent lights, minimizing clutter, and avoiding strongly scented candles, air fresheners and perfumes.

Sustaining effort and persistence

Sustaining effort and persistence in therapeutic engagement is achieved by heightening the salience of goals and objectives, varying demands and resources to optimize challenges, fostering collaboration and community, and increasing mastery-oriented feedback (CAST, 2018).

Social workers already help clients understand and maintain focus on clear and purposeful goals through multiple techniques, including the use of SMART (or specific, measurable, attainable, results-oriented, and time-bound) goals in therapy (Ralabate, 2016). Social workers should strive to ensure that goals are well understood by their clients. To accomplish this, social workers can utilize strategies like asking clients to repeat and restate goals back to them, breaking goals into shorter more manageable objectives, and providing prompts periodically to remind clients of their goals. Additionally, all feedback should be specific and relevant to the person and within their locus of control (CAST, 2018). Feedback should be frequent and timely and emphasize strategies for improvement when facing challenges (CAST, 2018).

Fostering collaboration and community also helps to sustain effort and persistence (CAST, 2018). In many ways, the COVID-19 pandemic has further highlighted the need for connection and community for optimal mental health (Killgore, Cloonan, Taylor, & Dailey, 2020). While we know that social inclusion and a sense of community can combat loneliness and contribute to other positive outcomes (Amado, Stancliffe, McCarron, & McCallion, 2013), people with IDD are especially vulnerable to loneliness and isolation and face many obstacles to social inclusion and community integration, including discrimination and stigma (Stancliffe et al., 2007). To combat this, social workers can

utilize group therapy or emphasize the importance of collaboration with trusted family members, friends and others to work toward identified goals. Additionally, social workers can provide informational & referral services to help their clients access community supports and organizations, such as libraries, clubs, or other public spaces that promote community inclusion.

Self-regulation

Effective self-regulation skills are vital to therapeutic engagement, particularly when the therapy focuses on helping clients with trauma experiences (Kraybill, 2018). For clients to build self-regulation skills successfully, they must engage in effective self-assessment and reflection and remain motivated to do so. Social workers can help clients regulate their emotional responses by assisting them in learning to mentally scan their bodies, be present in the moment, and express themselves effectively. These skills can be taught by engaging in mindfulness exercises, which can also help build focus and empathy (Turner, 2009).

Additionally, explicit instructions, modeling, and tools such as smartphone apps and reminders, checklists, and charts, can help clients learn to regulate their emotional responses as well as support them in tracking progress and maintaining motivation (CAST, 2018; Stawarz, Cox, & Blandford, 2015).

Provide multiple means of representation

Providing multiple means of representation involves providing the client with various ways and materials to understand information during the therapeutic process. This principle of UDL aligns closely with the 2015 NASW Standards and Indicators for Cultural Competence in Social Work Practice. UDL guidelines for providing multiple means of representation include 1) Perception, 2) Language and Symbols and 3) Comprehension (CAST, 2018).

Perception

All information, including advertising, intake materials, insurance forms, in-session materials, and "homework," should be customizable and available in multiple formats.

Written materials

Considerations include text size, font type, text color, color contrast, and spacing. Accessible Web (2021) recommends utilizing a minimum text size of 16pt, with the ability to resize all text to 200% of its original size, as well as

choosing color combinations with a high level of contrast between text and backgrounds. Additionally, color combinations such as red/green, which may be problematic for people with colorblindness, should be avoided.

Electronic documents

Electronic documents offer a level of malleability that is not possible with traditional printed or written text sources. With electronic documents, text size and color can more easily be manipulated by the user to meet their needs. An additional advantage of using electronic text is the availability of a wide variety of text-to-speech tools. These tools offer an additional mode of conveying information, and can increase reading comprehension in people with learning disabilities (Wood, Moxley, Tighe, & Wagner, 2018).

Audio

Information conveyed only through sound is not equally accessible to all clients (CAST, 2018). Written transcripts or closed captioning should be available for video and audio files. If playing an audio clip or giving information verbally, consider adjustments to volume and speed of the playback or speech. Additionally, social workers should allow for pauses for silence, as some clients, such as those with autism, may need additional time to process and formulate responses to verbal information (Maddox et al., 2020).

Visuals

When using visual representations, such as videos or photos, supplement with verbal descriptions, captions, or written descriptions of the content of images. Some clients might benefit from receiving visual information (such as charts, graphics, or written text) in addition to auditory stimuli. For example, a social worker might consider color-coding details on a chart for a client while also speaking the information aloud.

Language and symbols

To ensure therapeutic communication is understood by a wide variety of clients, it is important to use clear concrete language, avoid jargon and metaphors, clarify vocabulary and symbols, and take extra time to explain concepts and terms as needed. Social workers can consider providing clients with a glossary or dictionary of common terms and concepts. This could include charts, images, and other visuals, along with explanations. In other bodies of text, social workers can consider highlighting complex words or reading and reviewing them along with the client. Additionally, the NASW Standards and Indicators for Cultural Competence in Social Work Practice (2015) direct all social workers to strive to provide written materials in the

client's chosen language and provide professional interpreters (including sign language interpreters) when needed (National Association of Social Workers, 2015).

Comprehension

During therapy, clients take in new information in order to build skills. Clients will more easily assimilate or use this new knowledge if they have relevant background knowledge. However, some clients either lack the background knowledge to use new information or have background knowledge but don't know how to apply it (CAST, 2018). Social workers can begin working to supply background information and increase comprehension from the first session by explaining the intake process, what therapy is, the idea of informed consent, and other concepts, while leaving ample time for the client to ask clarifying questions. Social workers can also employ various strategies, including the use of graphic organizers, flow charts, tables, and concept maps, to help clients link new ideas to previous knowledge (Reid et al., 2017). Additionally, social workers can support clients with information processing by presenting information in blocks of related concepts, and giving information in a sequenced order to increase retention (CAST, 2018).

Provide multiple means of action and expression

All clients have different preferred methods for communication. Some clients may express themselves best in written language, some may prefer verbal speech, and still others may communicate best by utilizing technology (CAST, 2018). Providing clients with multiple options for action and expression allows them to increase their executive functioning and fully express their feelings and thoughts. UDL guidelines for providing multiple means of action and expression include 1) physical action, 2) expression and communication, and 3) executive function (CAST, 2018).

Physical action

Invariably, social workers will supply certain materials requiring client interaction. For example, social workers might utilize workbooks, journals, or calendars and charts to be filled in by the client. Some of these may require physical abilities, dexterity, and motor demands that not all clients possess. Having interactive materials available in a variety of formats (e.g. hard-copy, large print, and electronic) allows clients the opportunity to select a version that is easiest for them to interact with physically. For some clients, keyboards, headphones, or voice control methods may be the best option for their interaction with materials.

Expression and communication

Social workers should be prepared to allow clients to interact in their preferred way. Some clients will use methods of communication other than speaking. Some clients may use assistive technology to communicate. Other clients may simply prefer to communicate through written or typed words rather than verbally. For example, some clients may communicate feelings and emotions best through creative expression, such as art. Art offers a channel to promote self-expression, self-exploration, communication and personal development (Blomdahl, Gunnarsson, Guregård, & Björklund, 2013). Other expressive modes of interaction may include music, drama, and dance. Social workers can also consider helping clients use options like social media or manipulatives, such as toys displaying different expressions to represent feelings, as forms of communication.

One option for employing written expression is the use of journaling as a clinical tool. Journaling has been extensively studied as a therapeutic tool (Miller, 2014), and can be accomplished using pen and paper or electronically (including speech-to-text software and apps). Journaling may involve integrating information relevant to the treatment and frequent, structured opportunities for the client to reflect on and discuss the material presented. Journal pages can also include images, sound, tactile materials, or other features that may appeal to a wide range of clients. Some clients may also benefit from therapeutic role-playing as a method of expression and communication. Therapeutic role-playing is valuable for addressing a variety of therapeutic goals, but it is especially useful for helping clients combat specific phobias (Fritscher, 2020). Another potential novel option for social workers to facilitate expression and communication is virtual reality therapy. While virtual reality has most often been used as a mode of administering exposure therapy, it can have other therapeutic uses as well (Senson, 2016).

Executive function

Many clients will need support with high-level executive functions, such as setting long-term goals and developing strategies to meet these goals (CAST, 2018). Social workers can support clients with goal-setting by providing examples and goal-setting templates to help them think through realistic goals and the efforts needed to reach those goals (Reid et al., 2017). In other words, social workers should help clients identify the "why, how, when, and with who" of their goals. Social workers also might perform check-ins over the phone, encourage the client to check in with a friend via phone or social media, or utilize an app designed to help with accountability. Finally, social workers can help clients manage information and

monitor their progress by providing aids such as checklists, tools to record verbal notes, apps, and visual representations of progress such as pictures or charts (CAST, 2018).

Conclusion

A UDL framework in clinical practice can create environments that are more flexible and equitable for all clients. Even if unfamiliar with UDL principles, social workers already strive to meet the spirit of UDL by developing therapeutic spaces that are approachable and individualized for all clients. By systematically deploying UDL principles, access and potential benefit of clinical services for everyone is enhanced. Most important, UDL gives social workers a set of practical tools that creates a welcoming and accessible approach for people with IDD, who have been too long excluded from developing important therapeutic alliances and fully engaging in the therapeutic process.

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