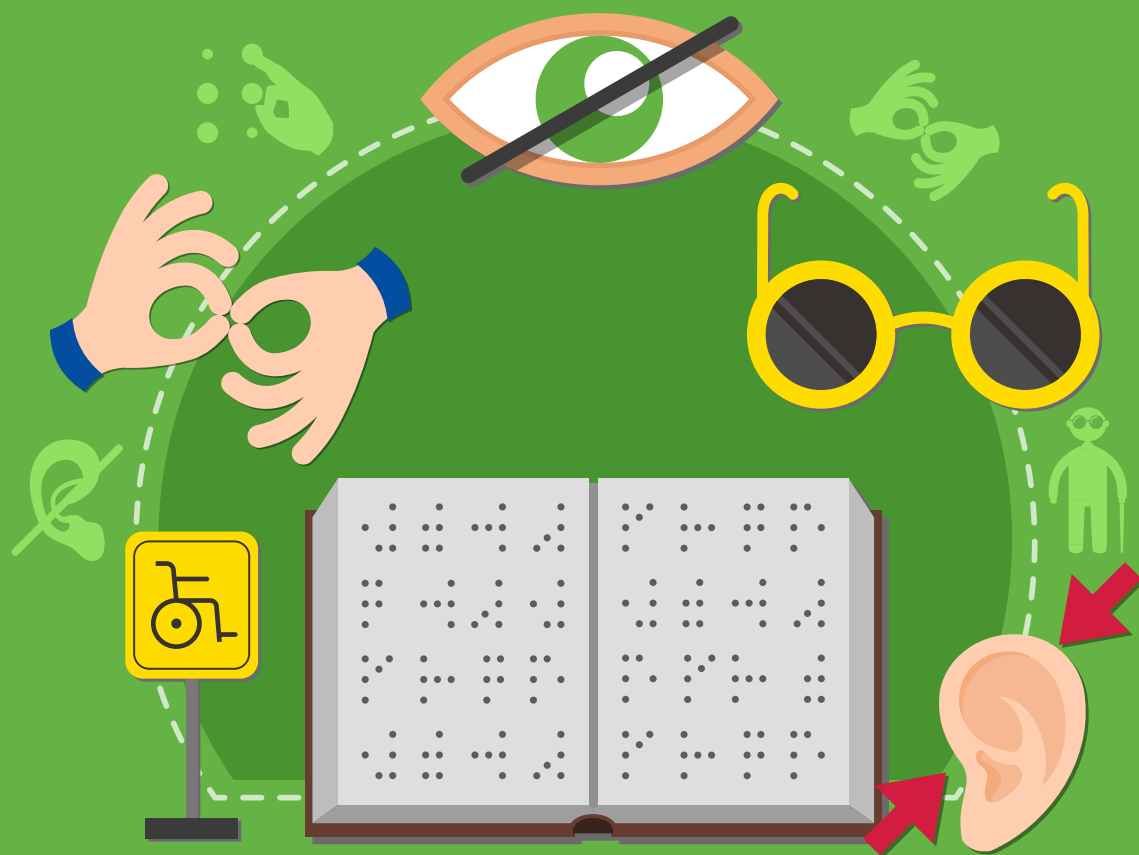


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Erasmus+ KA2 Partnership Project

# MANUAL FOR FACILITATION OF SOCIAL, MEDICAL AND EDUCATIONAL PROFESSIONALS IN WORKING WITH YOUNG PEOPLE WITH DISABILITIES

A CROSS-SECTOR TOOLKIT FOR COORDINATED, INCLUSIVE AND PARTICIPATION-  
FOCUSED SUPPORT (AGES 8–28)



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# ABOUT THE PROJECT CONSORTIUM & AUTHORSHIP

This Manual was developed within the Erasmus+ KA2 project “**I, You, We, They Can**” (2025–2026).

**Lead organisation (author):** Equality NGO (Macedonia)

**Project partners (contributors):** IDEA – Ajuntament d’Alzira (Spain) and Reflections on Europe (Poland)

The consortium brings together complementary expertise in inclusive practice, municipal coordination, policy development and cross-sector collaboration. The Manual is grounded in applied research, professional consultation and international study visits conducted in North Macedonia, Spain and Poland.

The content reflects joint authorship and shared responsibility of the partner organisations. It is designed as an operational resource for institutions in education, health/rehabilitation and social/community services, and may be adopted at institutional, municipal or national level.

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## EXECUTIVE SUMMARY

Inclusive education, healthcare/rehabilitation and social/community services often operate in parallel rather than as a coordinated system. Across partner contexts, the core challenge is not the absence of policy or professional commitment, but the absence of reliable coordination routines connecting institutions around one young person. As a result, families frequently become informal coordinators, outcomes depend on individual goodwill, and participation declines most sharply during transitions (school changes, child-to-adult services, and entry into vocational training, higher education or work).

The Manual for facilitation of social, medical and educational professionals in working with young people with disabilities proposes a practical, low-burden approach that turns existing obligations and professional knowledge into consistent daily practice across the three sectors. It provides:

A **coordination model** based on one shared support plan, one named coordinator, short interdisciplinary meetings when needed, and outcome-focused reviews every 6–8 weeks.

A **toolkit** of one-page templates (plans, checklists, meeting records, trackers, crisis and transition tools) that make decisions, owners, deadlines and evidence visible and transferable across staff changes.

**Minimum standards** that can be applied across different resource levels: minimum coordination standard and minimum communication access standard (so participation, consent and dignity are protected everywhere).

**Key note:** This Manual does not require legal reform. It operationalises existing obligations through simple coordination routines that institutions can implement immediately.

Who this is for: school directors and support teams, municipal coordinators, ministries and policy leads, and frontline professionals in education, health/rehabilitation and social/community services. The Manual can be adopted at institution level as a routine (minimum standard) and used in real cases through the tool pack.

## PART I - CONTEXT, RATIONALE AND ANALYTICAL FRAMEWORK

### 1. Introduction

The **Manual for facilitation of social, medical and educational professionals in working with young people with disabilities** was developed within the Erasmus+ KA2 project “**I, You, We, They Can**” (2025–2026), led by **Equality NGO** (Macedonia) in partnership with **IDEA – Ajuntament d’Alzira** (Spain) and **Reflections on Europe** (Poland). The partnership combines complementary expertise: Equality’s long-term practice in inclusion and disability support, IDEA’s municipal coordination experience in Alzira and the Valencia region, and Reflections on Europe’s perspective on policy, education reform and cross-European collaboration. Together, the partners developed a Manual that is both practical for service providers and credible for institutions responsible for organising inclusive services.

#### 1.1. Project background, goal and scope

The project responds to a shared European reality: while policies increasingly support inclusion, daily practice across education, healthcare/rehabilitation and social protection often remains inconsistent. The goal of the project, and this Manual, is to strengthen professional

capacity across the three sectors so that support for young people with disabilities and special educational needs (SEN, ages 8–28) becomes coordinated, accessible and participation-focused. The Manual is designed to be usable at two levels: it supports frontline professionals in real cases, and it supports managers and institutions in structuring procedures that improve consistency and continuity.

## 1.2. Why this Manual is needed now

In practice, the most frequent barrier is lack of a workable system that connects services. Young people and families often experience support as a sequence of isolated actions - appointments, school decisions, referrals - without a shared plan that follows the person across institutions. During the project, partners repeatedly observed the same pattern: services exist, but coordination fails at operational level. This creates uneven access, increases family burden, and makes outcomes depend on individual professionals rather than institutional standards. The need is especially visible during transitions: changing schools, moving between child and adult services, and entering vocational training, higher education or work.

## 1.3. What change does the Manual propose in the three sectors

The Manual proposes a change that is systemic in direction, but realistic in implementation: **from fragmented support to coordinated, participation-focused support**. This means shifting professional attention away from “what service is delivered” toward “what participation improves” and “how institutions cooperate to sustain that improvement.”

SECTOR	PRESENT	GOALS
Education	From <b>presence-based inclusion to meaningful participation</b> in learning and school life	Reasonable accommodation; accessible communication; shared planning and coordinated support with health/rehab and social/community services.
Health and rehabilitation	From <b>isolated clinical outputs to functional, context-linked goals</b>	Recommendations tied to real daily settings (school, home, community); practical actions aligned with other sectors; consistency and follow-through.
Social protection and community services	From <b>administrative handling and referrals to active continuity and inclusion support</b>	Coordinated continuity, inclusion and transition support; reduced isolation; prevention of resignation from services; sustained participation.

## 2. Methodology and Knowledge Base

Grounded in research, professional consultation and direct observation of real service environments across partner regions, the methodology ensures the Manual reflects real professional challenges and solutions that can be implemented even with limited resources.

### 2.1. Methodological approach

Developed through a qualitative, participatory and comparative approach, the methodology is based on research into relevant inclusion and disability support frameworks, analysis of national and local practice in the three sectors, and structured consultation with professionals, young people with disabilities and families. The partners compared practices across contexts

to identify what consistently improves outcomes and what consistently undermines inclusion. Drafts were reviewed and refined through expert collaboration and partner feedback, ensuring clarity, usability and cross-sector coherence.

The methodology prioritised a practical outcome: turning evidence and experience into guidance that can be used in everyday professional work - clear steps, short checklists, templates, all linked to real observed obstacles.

## 2.2. Role of international study visits as applied research

International study visits in 'I, You, We, They CAN' were used as applied research in real service environments—not as study tours. Across three locations, mixed teams from education, health/rehabilitation and social services observed practice, compared coordination routines, and translated what works (and what fails) into replicable tools and minimum standards.

**Study visit 1 – Skopje Region (N. Macedonia), hosted by Equality NGO.** The visit showed committed practice under resource constraints and a recurring pattern of families carrying coordination between institutions. Partner discussions with local and national stakeholders, combined with field observations in service settings, reinforced the focus on low-resource adaptations, minimum operational standards and a single shared plan that reduces family burden.

**Study visit 2 – Alzira and Valencia Region (Spain), hosted by IDEA – Ajuntament d'Alzira.** The visit highlighted the strength of municipal responsibility and clearer cross-sector procedures. Partners observed structured interdisciplinary collaboration and inclusion pathways linked to skills/employability, and captured examples of practical innovation for access to information and services in times of disruption. These insights strengthened the 'one shared plan + one coordinator + regular review' routine.

**Study visit 3 – Kielce and Świętokrzyskie Voivodeship (Poland), hosted by Reflections on Europe.** The visit demonstrated strong specialist expertise and municipal inclusion ecosystems that connect education, social support, culture and work training. It also confirmed that information flow and transition planning (especially school-to-adulthood) remain frequent weak points—supporting the emphasis on structured information sharing, transition tools and outcome review.

## 2.3. Pre-study visit surveys and baseline evidence

Before the international study visits, partner teams conducted short surveys with professionals and young people with disabilities and families. The surveys served as baseline needs assessment and a knowledge base for selecting study-visit focus areas and shaping the toolkits in this Manual. Across contexts, responses converged around the same implementation gaps: communication access, practical inclusive skills, weak cross-sector coordination and limited outcome-focused follow-through.

THEME / FINDING	BASELINE SUMMARY
Skills & training capacity	Skills and training are present but uneven; many report partial confidence and ask for practical, case-based methods (easy-to-read, Augmentative and Alternative Communication-AAC, sensory adjustments, respectful communication, usable coordination routines).
Coordination	Services often operate in parallel, increasing family burden and weakening continuity.
Communication & attitudes	Communication and attitudinal barriers are often more disruptive than physical barriers, especially in education and healthcare and rehabilitation.
N. Macedonia baseline	Average user satisfaction: <b>2.88/5</b> ; weakest perceived support among people with intellectual, neurological and complex disabilities.
Poland baseline	Overloaded, fragmented support system; access and follow-through depend heavily on local capacity and informal goodwill.
Spain baseline	High awareness of legal obligations, but gaps in consistent application; engagement/outreach can be a barrier.

These baseline findings are used as a starting point of the workflow design: one shared plan, a minimum standards gate, scheduled 6–8 week reviews, and an action register with owners, deadlines and evidence. In other words, the toolkit converts expressed needs into repeatable professional routines and institutional procedures.

### 3. Accessibility, Infrastructure and Adaptability

This section sets the baseline for inclusive practice: accessibility must be treated as a precondition, not a “special solution.” It also recognises that infrastructure varies widely and that the Manual must remain usable across contexts without lowering standards. The goal is to make inclusion practical and consistent even when resources are lacking.

**Accessibility as the foundation of participation** - Communication accessibility is central, because without accessible communication there is no meaningful consent, no reliable participation, and no shared planning. Accessibility also includes the environment (noise and sensory conditions), digital access (information formats), and attitudinal access (respectful interaction and absence of stigma). Accessibility is therefore linked not only to equipment, but also to professional behaviour, institutional procedures and the organisation of services.

**Infrastructure realities and why adaptability matters** - Across partner regions, differences in infrastructure were significant: specialist availability, access to assistive technology, staff training opportunities, and the maturity of cooperation mechanisms all varied. Instead, it defines what must be protected everywhere (dignity, access, coordination) and shows how to adapt methods to context. Adaptability is treated as a core competence: adjusting approaches without reducing rights or excluding the young person.

**Minimum operational standard** - To prevent “inclusion” from becoming dependent on individual effort, the Manual defines a minimum operational standard that institutions can implement

even under constraints. Where resources are limited, the Manual prioritises low-cost, high-impact adjustments: structured routines, environmental changes, clear role division, and consistent cross-sector communication..

## 4. Cross-Institutional Collaboration

Coordination challenges are often described abstractly, while professionals need concrete mechanisms. Collaboration is treated, not as a “soft skill”, but as an operational structure that can be designed and improved.

### 4.1. Who needs to collaborate and why?

Effective support requires cooperation across institutional levels.

#### ROLES THAT SHAPE ACCESS AND EVERYDAY INCLUSION

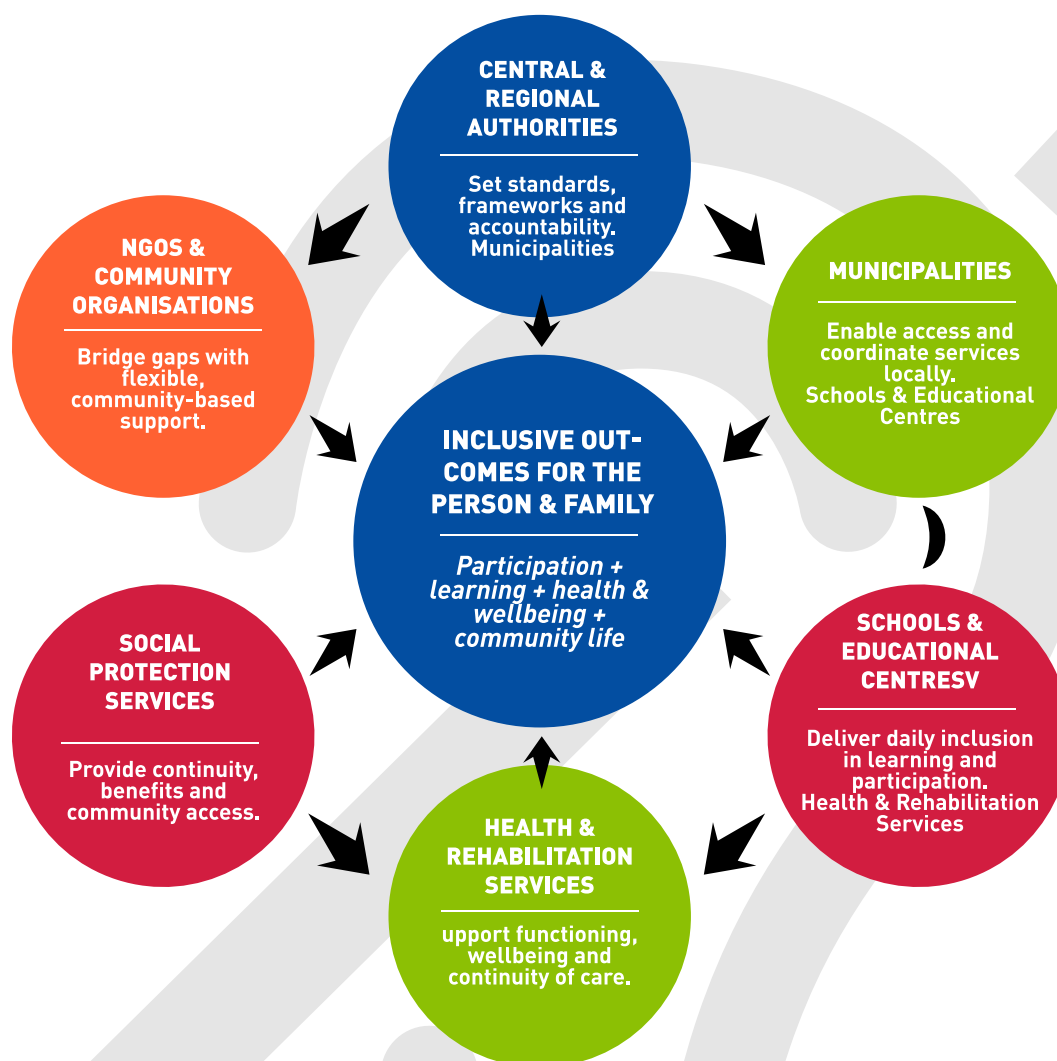


Figure 1 - ECOSYSTEM OF INCLUSIVE SUPPORT

When all relevant actors work independently, young people receive fragmented support. When actors work with shared goals and tools, inclusion becomes consistent and sustainable

## 4.2. Policy implementation challenges

Across partner contexts, the key barrier is not the absence of policy, but uneven implementation - limited professional capacity, fragmented responsibilities across institutions, inconsistent service availability, and weak monitoring can turn legal commitments into “rights on paper” rather than reliable everyday practice. At the benchmark level, the UN Convention on the Rights of Persons with Disabilities (CRPD) requires effective inclusion in education and community life and meaningful participation in decisions, setting a clear standard against segregation and passive “service delivery” models.

Spain has a strong legal backbone through the General Law on the Rights of Persons with Disabilities and their Social Inclusion (Royal Legislative Decree 1-2013), yet implementation can differ across territories and services due to decentralised delivery and variable local capacity (staffing, training, coordination routines). Poland anchors school system duties in the Act Education Law (Prawo oświatowe, 14 December 2016), but practice-level inclusion and coordinated support still depend on whether institutions operationalise responsibilities (shared planning, communication access, continuity between services) beyond formal compliance. N. Macedonia has advanced reforms through the Law on Social Protection (2019) and the Law on Primary Education (2019) and upcoming strategies prepared by the Ministry of Education, yet implementation remains challenged by uneven municipal resources and limited availability of trained support staff and consistent inter-institutional routines.

A clear gap exists between “what policy says” and “what services do.” The Manual does not attempt to replace policy, but to offer practical mechanisms that help institutions implement policy through everyday routines.

## 4.3. Obstacles to effective collaboration

In practice, collaboration breaks down in predictable ways: institutions produce parallel plans that do not align; information is either not shared or shared without purpose; there is no single coordinator; and time pressure discourages communication. The result is that families repeat the same information across services and crises escalate because early coordination did not happen. These obstacles are systemic, not individual, and therefore require a structural solution.

## 4.4. Proposed solution: from miscommunication to goal-focused cooperation

A pragmatic collaboration model designed for real conditions: one shared support plan, one named coordinator, short interdisciplinary meetings using a fixed agenda, and outcome-focused reviews at agreed intervals. This model replaces informal, person-dependent communication with a minimal but reliable structure. It is designed to reduce duplication, prevent gaps, and keep the focus on participation outcomes rather than administrative processes.

# 5. Approaching Young People with Disabilities: The Service Provider Perspective

Professionals must understand that it is not enough to “provide services”, but rather how their approach affects dignity, engagement and participation. The Manual therefore promotes a consistent professional method across sectors, anchored in accessible communication and shared planning.

## 5.1. From diagnosis to needs, strengths and participation

Diagnosis can be relevant for understanding support needs, but it should never define the solution. Effective practice begins with understanding the young person’s strengths, preferences and participation goals, then identifying the barriers that reduce participation (communication barriers, environmental barriers, attitudinal barriers, and system barriers). This

approach is particularly important for young people with complex or combined needs, where narrow service perspectives can lead to exclusion or repeated crisis. Families are recognised as key partners in understanding context, but professional systems must carry responsibility for coordination.

## 5.2. Checklists as quality assurance tools

Because inconsistency is a core problem, the Manual includes checklists that help teams implement minimum standards reliably. These tools support staff in checking communication access, structuring shared planning, documenting responsibilities, and reviewing outcomes. Checklists are presented as supportive structures, not bureaucratic tasks: their purpose is to reduce risk, prevent exclusion, and improve continuity.

## 5.3. Continuous professional improvement and skills development

Accessible, respectful communication is not only an individual skill; it is an **institutional and system responsibility** that must be maintained through **continuous professional development**. Communication needs change across ages (8–28), settings and disability profiles, so professionals require regular opportunities to strengthen competence.

**Minimum standard for institutions/authorities to be ensured:** Each professional should have access to (a) **annual training** on inclusive communication and accessibility, (b) **practical supervision/mentoring** (case reflection, coaching, peer feedback), and (c) at least basic upskilling in **AAC, Easy-to-Read, sensory/environmental adjustments, and de-escalation communication**.

SKILLS OPPORTUNITIES	WHAT IT INCLUDES (PRACTICAL EXAMPLES)
State / regional / local support	Accredited trainings; municipal/regional cross-sector workshops (education–health–social); funded short courses; conference participation and knowledge exchange; supported professional networks / communities of practice.
Institution-level support	Induction for new staff; in-house or outsourced coaching; regular case reflection using the Manual’s tools; peer observation; protected learning time (not “extra work”).
External partnerships	Cooperation with NGOs, universities, professional associations and specialist centres; targeted training delivery; joint cross-institution sessions to increase consistency and reduce cost.

## 6. Evaluation and Feedback

In inclusive systems, improvement depends on feedback mechanisms: services adjust when outcomes are not achieved, and successful methods are reinforced and shared, applicable across the three partner regions and replicable in other European contexts, positively influencing the development and success of the systemic practices. The Manual therefore includes a minimum evaluation approach focused on what matters most: participation, accessibility, continuity and dignity.

Evaluation is based on three complementary sources:

1. Feedback from professionals (changes in practice, coordination, confidence),
2. Feedback from young people and families (access, participation, respect),
3. Outcome indicators that are simple enough to review regularly (participation/attendance,

crisis reduction, continuity of support).

This approach supports both professional learning and institutional accountability.

## PART II - PRACTICAL GUIDANCE AND TOOLKIT

Practical Guidance and Toolkit translates the analytical framework presented in Part I into **concrete professional action**. While Part I explains *why* coordinated, inclusive support is necessary and *what* systemic challenges must be addressed, Part II focuses on *how* professionals and institutions can work differently in everyday practice.

The guidance in this part is intentionally **cross-sectoral**. It recognises that education, healthcare/rehabilitation and social protection operate within different fields yet share responsibility for the same young person. The tools and approaches presented here are designed to be used jointly, adapted to local conditions, and applied consistently across institutions.

This section is informed by partner experience and study visits coordinated by **Equality NGO, IDEA – Ajuntament d’Alzira**, and **Reflections on Europe**, ensuring that guidance reflects real service environments rather than idealised models.

### CROSS-SECTOR PATHWAY FOR COORDINATED, PARTICIPATION-FOCUSED SUPPORT

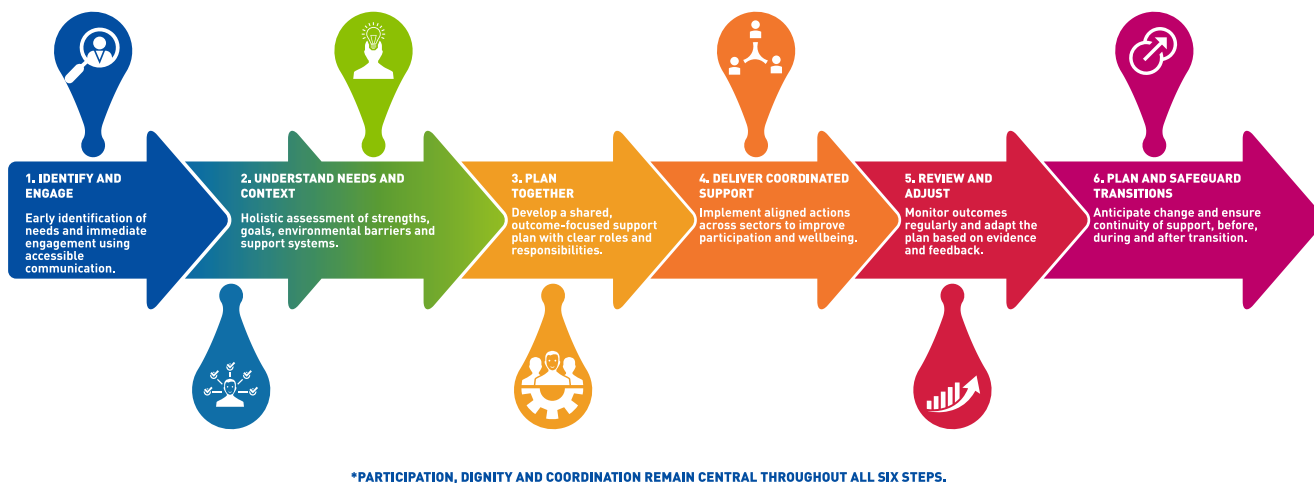


Figure 2 - SIX-STEP PROFESSIONAL APPROACH

## 7. Scope and Key Definitions for Practice

Before introducing tools and procedures, it is essential to clarify how key terms are used in daily professional work. Shared understanding reduces miscommunication and prevents conflicting interpretations across sectors or supports services delivery approaches.

The Manual applies to **young people aged 8–28** with physical, sensory, intellectual, psychosocial or multiple disabilities and/or SEN. The age range reflects the reality that support needs do not end with compulsory schooling and that transitions to adulthood require structured attention.

For practical purposes, the following developmental stages are used:

- **8–12 years:** foundations for learning, communication and early participation, with strong family involvement.
- **13–17 years:** adolescence, identity development, behavioural and mental health considerations, increasing autonomy.
- **18–28 years:** transition to adulthood, further education, employment, independent or supported living.

Key operational terms such as *participation*, *accessibility*, *reasonable accommodation*, *shared support plan* and *case coordinator* are used consistently across all sectors to ensure alignment.

## 8. The Cross-Sector Pathway for Coordinated Support

The Cross-Sector Pathway for Coordinated Support provides a common sequence of action regardless of which field does the young person approach the system from.

### 8.1. Why a shared pathway is necessary?

In fragmented systems, support often depends on who initiates action and how persistent families are. A shared pathway reduces variability by providing a predictable structure that professionals can follow, even under time pressure.

### 8.2. The Six-Step Professional Approach pathway explained

- **Identify and engage**  
Entry may occur through a school, clinic, social service or NGO. At this stage, communication access must be checked immediately.
- **Understand needs and context**  
Professionals jointly explore strengths, preferences, participation goals and barriers. This step moves beyond diagnosis to include environmental and social factors.
- **Plan together**  
A **Shared Support Plan** is created or updated. Responsibilities and timelines are agreed across sectors.
- **Deliver coordinated support**  
Each sector implements its part of the plan in alignment with others, avoiding contradictory actions.
- **Review and adjust**  
Outcomes are reviewed at agreed intervals (typically every 6–8 weeks), and the plan is adapted if participation does not improve.
- **Plan transitions**  
Transitions between stages or systems are anticipated early, with continuity ensured.

### 8.3. Minimum coordination standard

To make the pathway operational, the Manual defines a minimum standard:

- one shared plan,
- one named coordinator,
- at least one interdisciplinary meeting when complexity increases,
- documented decisions in accessible language,
- a clear review date.

This standard is achievable in most contexts and prevents reliance on informal or person-dependent coordination.

## 9. Accessible Communication and Relationship-Based Practice

Accessible communication is the foundation of trust, participation and effective support. This section explains how institutions and professionals can embed accessibility into routine practice.

### 9.1. Minimum communication access standard

Before decisions are made, professionals should ensure that:

- the young person's abilities to learn, communicate and live independently or with support,
- the preferred communication method of the young person is identified,
- language and format are adapted to their needs,
- sensory and environmental factors are considered,
- understanding is actively checked,
- sufficient time is allowed for response.

These steps are not optional accommodations; they are essential for ethical and effective practice.

### 9.2. Communication with young people

Professionals are expected to address the young person directly, explain options clearly, and support expression through all available means (speech, visuals, AAC, behaviour). Respectful communication increases engagement and reduces distress.

### 9.3. Communication with families and caregivers

Families should be informed transparently and treated as partners, but should not be expected to compensate for system fragmentation. Professionals should clarify roles, acknowledge stress, provide accessible information and ensure follow-up. Disciplinary language and unrealistic expectations must be avoided.

Institutions are responsible for ensuring that staff receive training in inclusive communication and that accessible formats are available as standard practice.

## 10. Behaviour Support and Crisis Prevention

Behaviour Support and Crisis Prevention addresses one of the most challenging aspects of practice: responding to distress and behaviour that challenges services. Guidance is intentionally balanced here to prevent crisis and provide clear direction.

### 10.1. Understanding behaviour

- Behaviour is understood as a form of communication reflecting unmet needs, environmental stressors or lack of appropriate support. Viewing behaviour in this way prevents escalation and exclusion.

### 10.2. De-escalation in practice

Effective de-escalation follows a clear sequence:

- professionals regulate their own response,
- demands are reduced,
- dignity and safety are protected,
- connection and communication are restored.

### 10.3. Learning after incidents

After an incident, teams should review what contributed to distress, what helped, and what needs to change. The focus is learning and prevention, not disciplinary approach.

Disciplinary responses, routine exclusion and restraint for convenience are identified as practices to be avoided.

## 11. Sector-Specific Guidance

The Sector-Specific Guidance section clarifies how each sector contributes to the shared plan while maintaining its professional mandate.

### 11.1. Education

Education professionals are responsible for enabling participation in learning and school life. This includes adapting tasks and environments, preventing exclusion, coordinating with other sectors, and supporting transitions between grades or schools. It shall be an intuitive and complementary to systemic educational inclusive practices.

### 11.2. Health and rehabilitation

Health and rehabilitation professionals link clinical assessment to everyday participation. Recommendations should be understandable, feasible and coordinated with education and social services. This includes applying innovative rehabilitation methods that improve quality of life and strengthen systemic support.

### 11.3. Social protection and community services

Social services support inclusion beyond institutions by facilitating access to community resources, safeguarding dignity, and ensuring continuity during transitions to adulthood. New models of collaboration between social and community services should involve specialised experts and organisations in order to strengthen systemic solutions.

Across all sectors, coordination and communication are treated as core professional responsibilities.

## 12. Transitions and Continuity of Support

Transitions are predictable risk points. This section emphasises that transitions must be planned early, coordinated across sectors, and supported until new arrangements are fully in place.

Professionals should anticipate transitions 12–24 months in advance, involve all relevant services, and ensure information transfer with consent. Abrupt service endings and “handover without meeting” practices are explicitly discouraged.

### 12.1. Case scenario: Transition planned vs. transition unmanaged

This scenario illustrates how the same young person can experience different outcomes depending on whether the transition is planned early and coordinated, or left to a late, informal handover.

GOOD TRANSITION PRACTICE	POOR TRANSITION PRACTICE
<p>Alexandra (17) is moving from lower to upper secondary. 12 months before the change, the school, health/rehab provider and municipal social service name a coordinator and start F4 (Transition Continuity Plan). They document 'what works' (communication profile, sensory adjustments, learning supports, crisis early-warning signs) and schedule a joint meeting with the incoming school team. Support continues until the first review in the new setting confirms stabilisation (6–8 weeks).</p>	<p>Alexandra's change is addressed late (a few weeks before the new school starts). There is no named coordinator and no joint meeting. Information is transferred informally (emails without structure, missing consent, no clear 'what works' page). Outgoing support ends on the last day of school even though the incoming setting is not ready.</p>
<p><b>Result:</b> Alexandra starts the new school with predictable routines and accessible communication. Attendance is stable, distress incidents decrease, and family burden drops because owners and deadlines are clear.   <b>*Tools used:</b> F4 (planned milestones + continuity safeguard), S1 (minimum standards at intake/first meeting), F1 (updated shared plan), R1 (actions with owners/deadlines), R2 (first review decision).</p>	<p><b>*Result:</b> Alexandra misses school days, becomes distressed due to sensory overload, and the family is forced to explain the situation repeatedly. A crisis meeting is called only after escalation, and exclusion is discussed as a 'solution'   <b>*Typical recovery steps:</b> run S1, hold F2 meeting within 5 working days, create/repair F1 + R1, and activate F3 if incidents recur; start F4 even if late to prevent further drop-off.</p>

### 13. Safeguarding, Consent and Data Sharing

Safeguarding is a shared responsibility. Professionals must remain alert to risk, ensure accessible consent and assent, and share information responsibly. Data sharing should be purposeful, proportionate and documented, balancing protection with effective cooperation.

### 14. Tool Pack Overview

A structured tool pack is included, consisting of shared plans, meeting agendas, communication and behaviour tools, transition plans, outcome trackers, checklists and practices to be used or practices to be avoided. Each tool is designed to be one page, adaptable and usable across sectors.

## PART III - PROFESSIONAL TOOLKITS, CHECKLISTS AND TRACKING GUIDES

### Introduction to the Toolkits

The following toolkits are designed to support professionals and institutions in **their implementation in a consistent, measurable and sustainable way**. While the previous sections explained *how* to work inclusively and collaboratively, this part focuses on *how to ensure that the work is actually happening*, improving over time, and producing visible outcomes.

The toolkits serve three complementary purposes:

1. **Guidance** – helping professionals apply inclusive practice consistently.
2. **Coordination support** – helping teams track shared responsibility and continuity.

### 3. **Monitoring and learning** – helping institutions identify progress, gaps and priorities.

All tools are intentionally **simple, one-page or modular**, and adaptable to different resource levels. They are not intended to increase bureaucracy, but to **reduce risk, exclusion and fragmentation**.

## EVIDENCE & EXPERIENCE BASE

This Manual and the integrated Toolkits are grounded in cross-country analyses of negative practices in disability support across education, health/rehabilitation and social/community services. The evidence shows recurring implementation failures that can be reduced through structured coordination routines, clear accountability, and communication accessibility.

### 1) **Recurring negative practice patterns (cross-country)**

- **No outcome monitoring:** tracking service activity rather than participation and wellbeing outcomes; limited learning from incidents or stalled progress, quantitative monitoring and uneven implementation (Tools: R2, S2)
- **Exclusion as default response:** removal from mainstream settings, steering into segregated pathways, or refusal to provide reasonable adjustments (Tools: S1, F2, F3)
- **Fragmented support:** parallel plans, unclear roles, and reliance on families as the 'coordination party' between institutions (Tools: F1, R1, F2)
- **Communication inaccessibility:** information not provided in accessible formats (easy-read, sign language, AAC support), resulting in weak participation and compromised consent (Tools: S1, F1)

### 2) **How the toolkit assists professionals (frontline)**

- Supports preventive, dignity-preserving responses to distress episodes and reduces punitive reactions.
- Turns meetings into decisions with owners, deadlines, and review dates, preventing repeated discussions without action.
- Clarifies 'who does what by when' across sectors and records evidence of completion, supporting continuity under staff change.

### 3) **How the toolkit assists systemic solutions (institutional)**

- Strengthens implementation during high-risk moments (crisis and transitions) through escalation triggers and continuity safeguards.
- Identifies training and capacity gaps through recurring checklist flags (e.g., sign language access, cognitive accessibility, sensory adjustments).
- Enables accountability and auditability: decisions and follow-through are documented with evidence, supporting oversight and quality assurance.

## TOOLS & TEMPLATES SECTION

**Cross-sector inclusive support system for one young person (Education – Health/Rehab – Social/Community)**

### System logic (how the set works)

- **F1 Shared Support Plan** is the **single sufficient source** (one plan only).
- **S1 Minimum Standards Checklist** is the **quality gate** used at every key moment.
- **R1 Action Register** ensures **continuity + accountability** between reviews.
- **R2 Outcomes Tracker** turns reviews into decisions, not updates.
- **F2 Meeting Record** is used when the case is complex or progress stalls.
- **F3 Crisis Prevention Plan** reduces escalation and prevents exclusion.
- **F4 Transition Continuity Plan** protects support during change.
- **S2 Institutional Reflection** strengthens the system annually.

### Review default rhythm

- **Core review cycle:** every **6–8 weeks**
- **Fast review (risk):** within **5 working days** when triggers apply (see escalation rules)

## TOOLKIT SCHEDULE OVERVIEW (planned coordination calendar)

### Core schedule template (one per case)

Week 0–2	Week 2–6	Week 6–8	Triggers (any time)
Run <b>S1</b> and create <b>F1</b> and set baseline in <b>R2</b> .	Implement actions and log follow-through in <b>R1</b>	Review with <b>R2</b> and update <b>F1</b> ; schedule next review.	<b>2 missed deadlines - F2 meeting; 2 incidents / 4 weeks - go to review F3; transition confirmed - start F4.</b>

Case ID: \_\_\_\_ | Coordinator: \_\_\_\_ | Plan version: v\_\_ | Start date: //\_\_

# TOOLS & TEMPLATES (ready-to-use)

## S1 – Minimum Inclusive Standards Checklist (Quality Gate)

**Use at:** intake, before plan sign-off, before/after meetings, every review, transition planning, escalation.

**Rating:** 0 = No | 1 = Partly | 2 = Yes

**Rule:** Any score <2 must have **one fix + owner + deadline**.

### A) Communication & participation

- Preferred communication method identified (0/1/2)  Fix/Owner/Deadline: \_\_\_\_\_
- Accessible format provided (0/1/2)  Fix/Owner/Deadline: \_\_\_\_\_
- Young person addressed directly (0/1/2)  Fix/Owner/Deadline: \_\_\_\_\_
- Understanding actively checked (0/1/2)  Fix/Owner/Deadline: \_\_\_\_\_

### B) Coordination & accountability

- Shared Support Plan active (0/1/2)  Fix/Owner/Deadline: \_\_\_\_\_
- Coordinator named + contact shared (0/1/2)  Fix/Owner/Deadline: \_\_\_\_\_
- Actions have owner + deadline (0/1/2)  Fix/Owner/Deadline: \_\_\_\_\_
- Review date set + scheduled (0/1/2)  Fix/Owner/Deadline: \_\_\_\_\_

### C) Dignity, safeguarding, data

- Consent/assent accessible (0/1/2)  Fix/Owner/Deadline: \_\_\_\_\_
- Privacy respected (0/1/2)  Fix/Owner/Deadline: \_\_\_\_\_
- Risks considered + mitigation (0/1/2)  Fix/Owner/Deadline: \_\_\_\_\_
- Minimum necessary sharing only (0/1/2)  Fix/Owner/Deadline: \_\_\_\_\_

### D) Family partnership

- Family informed and consulted (0/1/2)  Fix/Owner/Deadline: \_\_\_\_\_
- Family not burdened with coordination (0/1/2)  Fix/Owner/Deadline: \_\_\_\_\_
- Written follow-up provided (0/1/2)  Fix/Owner/Deadline: \_\_\_\_\_

**Total: /24 | Next S1 check date: //**

KEY POINT	GOOD PRACTICES	BAD PRACTICES
<b>Minimum standards checklist stays an active quality gate</b>	Run S1 at the start of every meeting as a stop-check before decisions; if any item is <2, agree one fix you can implement within 7 days; share a one-page summary of fixes with owners and deadlines after the review.	Treat the checklist as a one-time form rather than a recurring quality gate; mark "Partly/No" without assigning a concrete fix, owner and deadline; use the checklist to justify reduced support, exclusion or delay; leave communication access undefined because "staff already know".

## F1 – Shared Support Plan (Single Sufficient Source)

**Case ID:** \_\_\_\_ | **Young person:** \_\_\_\_ | **Coordinator:** \_\_\_\_ | **Contact:** \_\_\_\_  
**Primary communication access:**  Easy-read  AAC  Interpreter  Sign  Other: \_\_\_\_  
**Institutions involved:** Education \_\_\_\_ | Health/Rehab \_\_\_\_ | Social/Community \_\_\_\_  
**Version control:** v\_\_ | Created //\_\_ | Updated //\_\_ | Next review //\_\_

### 1) What matters to the young person (use their words if possible)

Strengths/interests: \_\_\_\_\_  
 What a good week looks like: \_\_\_\_\_  
 What we must avoid (known distress triggers/approaches): \_\_\_\_\_

### 2) Participation goals (max 3) - SMART + measurable

Goal (observable)	Why it matters	Baseline (now)	Target (by date)	Review date
1.				

### 3) Barriers & enablers

Area	Barriers	What already works (enablers to replicate)
1.		

### 4) Cross-sector Action Plan (scheduled + evidence-based)

Action (deliverable)	Sector	Owner	Support	Deadline	Evidence of completion
1.					

### 5) Family partnership (agreed, realistic, not burdensome)

Family role (what they will do): \_\_\_\_\_  
 How professionals reduce burden: \_\_\_\_\_  
 Preferred updates (method/frequency): \_\_\_\_\_

### 6) Consent, safeguarding and information-sharing (minimum necessary)

Consent/assent status:  Yes  Partial  Pending (plan/date): \_\_\_\_\_

What can be shared, with whom, and why: \_\_\_\_\_

Secure method:  secure platform  encrypted email  in-person  other: \_\_\_\_

### 7) Review decision (must end in adjustments)

Status:  Improving  Stable  Declining

Adjustments before next review (1-3): \_\_\_\_\_

Next review date confirmed: //\_\_

KEY POINT	GOOD PRACTICES	BAD PRACTICES
Shared planning stays outcome-focused and reduces fragmentation	Keep goals to 2-3 and write them as observable participation outcomes; use baseline + target + review date so progress is measurable; write actions as deliverables with evidence (e.g., “adapted schedule issued” not “support provided”).	Run parallel plans with different goals across sectors; write goals as service activities instead of participation outcomes; add too many goals/actions; assign responsibility to families to coordinate; set deadlines without evidence criteria.

## R1 - Action Register (Continuity & Accountability Log)

**Use when:** After every action missed/blocked steps, repeated tasks without outcomes, weak follow-through, staff change, multi-sector coordination gaps.

**Rule:** If actions are repeated without outcomes → trigger **F2**.

Date	Trigger (why now)	Action/ Decision	Owner	Dead-line	Status (done/pending/blocked)	Evidence	Next step

KEY POINT	GOOD PRACTICES	BAD PRACTICES
Action tracking ensures accountability and continuity	Log decisions the same day they are made to avoid informal drift; use “blocked” only with a reason and the next escalation step; attach evidence links/notes (email, photo, appointment note) for audit and handover.	Record activity without outcomes (what changed/was delivered); leave actions without an owner and deadline; allow “blocked” items to repeat without escalation to an interdisciplinary meeting; rely on informal messages instead of logging key decisions for continuity.

## R2 - Outcomes & Milestones Tracker (every 6–8 weeks)

**Use when:** every 6–8 week review, outcomes stable/declining, need to decide adjustments, pre/post transition, post-incident or major change.

Review period: //\_\_ to //\_\_ | Reviewed by: \_\_\_\_ | Linked plan version: v\_\_

**Outcomes (baseline → current → target)**

Domain	Baseline	Current Status	Target (by date)	Notes

**Milestones this cycle (max 5)**

Milestone	Achieved	Partly	Not yet	Reason	Next action (owner/date)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Decision:

Continue as is  Adjust plan (update F1)  Meeting required (F2)  Escalation (F3)  Transition (F4)

KEY POINT	GOOD PRACTICES	BAD PRACTICES
<b>Outcome tracking</b>	Track 4 domains consistently; add notes only when they lead to a decision; use short numeric/observable indicators (e.g., “2/5 days attended”); if declining, agree 1–3 adjustments and assign them in <b>F1 + R1</b> .	Track too many indicators or change measures every cycle (loses comparability); record stable/declining without deciding and assigning an adjustment; interpret lack of progress as a reason to withdraw support rather than adapt it; ignore the young person’s view of what success looks like.

## F2 - Interdisciplinary Meeting Record (30–45 min, outcome-focused)

**Use when:** complex case, stalled progress, rising risk, pre/post transition, repeated missed actions.

**Date/time:** \_\_\_\_ | Chair: \_\_\_\_ | Note-taker: \_\_\_\_ | Duration: \_\_\_\_

Young person involved:  Present  Represented  Not involved (reason): \_\_\_\_

Communication access provided:  Yes  Partial  No → fix now: \_\_\_\_\_

**Agenda (time-boxed)**

1. Goal check (what changed since last review): \_\_\_\_\_
2. Barriers (top 2 blockers + evidence): \_\_\_\_\_
3. Decisions (actions only): \_\_\_\_\_
4. Review date set: //\_\_

**Decision table (mandatory)**

Decision / action	Owner	Deadline	Evidence	Shared with (who/how)

Closing reflection (coordination): What worked / what must improve: \_\_\_\_\_

KEY POINT	GOOD PRACTICES	BAD PRACTICES
<b>Interdisciplinary meetings produce decisions and follow-through</b>	Time-box agenda items and move to decisions once enough evidence is shared; use the decision table only - if it's not in the table, it's not agreed; update <b>F1</b> immediately after the meeting (same day).	Turn the meeting into status updates without decisions, owners and deadlines; discuss issues not linked to agreed participation goals; end without a review date or without updating the Shared Support Plan; fail to provide communication access for the young person/family involvement.

**F3 - Behaviour & Crisis Prevention Plan (Preventive, not punitive)**

**Use when:** recurring incidents, early warning signs, exclusion being considered.

Applies in settings/times: \_\_\_\_\_

Early warning signs (top 5): \_\_\_\_\_

Triggers (top 5): \_\_\_\_\_

Prevention schedule (what to do early)

Strategy (do)	Who applies	Where/when	What it prevents

**Response steps (during escalation)**

Step 1 (low): \_\_\_\_\_

Step 2 (medium): \_\_\_\_\_

Step 3 (high): \_\_\_\_\_

What to avoid (explicit): \_\_\_\_\_

Safety escalation (who calls whom, when): \_\_\_\_\_

### After-incident learning (within 48–72 hours)

What contributed? \_\_\_\_\_

What helped? \_\_\_\_\_

What changes now (owner + deadline): \_\_\_\_\_

**Review date:** //\_\_ | Trigger review: 2 incidents / 4 weeks

KEY POINT	GOOD PRACTICES	BAD PRACTICES
<b>Crisis planning stays preventive, practical, and dignity-preserving</b>	Describe early signs and supports in plain language any staff member can follow; prioritise prevention (environment + communication) before response steps; complete after-incident learning within 72 hours and change one system factor.	Use punitive language or frame behaviour as non-compliance rather than distress/needs; create a plan too complex to apply under pressure; ignore environmental/communication triggers and focus only on the individual; skip after-incident learning and repeat the same responses; use incidents to justify exclusion instead of adapting support.

## F4 - Transition Continuity Plan (12–24 months before change)

Transition type:  school change  adulthood  training/work  higher education  other:

Target date: //\_\_ | Coordinator: \_\_\_\_ | Incoming lead: \_\_\_\_ | Outgoing lead: \_\_\_\_

“What works” to replicate immediately (top 10): \_\_\_\_\_

### Milestones schedule

Milestone	Owner	Due date	Status	Evidence
1.				

### Continuity safeguard (check):

- Support continues until new services active
- Support continues until first review completed **(recommended)**

KEY POINT	GOOD PRACTICES	BAD PRACTICES
<b>Transitions protect continuity and reduce resignation risk</b>	Start with “what works” and make it transferable (one page); schedule the first follow-up in the new setting before the transition date; keep outgoing support active until the first review confirms stabilisation.	Start transition planning too late or without a named coordinator; transfer information without consent/ assent or via insecure channels; stop support before incoming services are active and stable; fail to document “what works” so the next setting can replicate it immediately.

## S2 - Institutional Self-Reflection (annual / post-change)

**Who use:** managers, coordinators, governance leads.

**Output:** 3 priority actions with owners and deadlines.

Question	Score	Evidence	Priority action	Owner	Dead-line
Roles + coordination + communication					
Shared plan used + outcomes reviewed					
Families supported, not overburdened?					
Data sharing “minimum necessary”?					

KEY POINT	GOOD PRACTICES	BAD PRACTICES
<b>Institutional reflection leads to real improvement</b>	Use evidence (samples of plans, logs, review dates) - not opinions only; pick 3 priority actions max and complete them within 90 days; repeat the reflection after a major staff/ organisational change.	Reflection as compliance paperwork rather than an improvement plan; list priorities without owners, deadlines/ evidence; focus only on training while ignoring process/system fixes; review annually without acting on recurring issues identified across cases.

# INCLUSIVE PRACTICES CHECKLIST

DOMAIN	PURPOSE	WHO USES IT	WHEN TO USE	OUTCOME AREAS	GOOD PRACTICE TIP
<b>1) COMMUNICATION &amp; PARTICIPATION</b>	Ensure communication access so participation, consent/assent and dignity are possible in every setting.	All professionals interacting with the young person; coordinator ensures consistency.	Intake; before meetings/decisions; reviews; whenever understanding/disengagement occurs.	More participation; improved consent quality; reduced distress linked to communication barriers; improved trust.	Write the communication profile in plain language so any staff member can apply it under pressure.
<b>2) COORDINATION &amp; ACCOUNTABILITY</b>	Prevent fragmentation by ensuring one shared plan, clear roles and follow-through across sectors.	Case coordinator + all involved services (education, health/rehab, social/community).	First joint planning; every review; when actions stall; before transitions.	Reduced duplication; faster response to barriers; continuity across staff changes; clear responsibilities.	End meetings with one sentence per action: "Who will do what by when (and what proves it)."
<b>3) DIGNITY &amp; SAFEGUARDING</b>	Protect safety, privacy and autonomy while enabling responsible collaboration.	All professionals; coordinators/managers for data-sharing and risk oversight.	Intake; reviews; information sharing; after incidents; during transitions.	Safer support; reduced legal/ethical risk; preserved dignity; stronger institutional trust.	Share what is needed to act - not full histories by default; record why/what/how shared.
<b>4) FAMILY PARTNERSHIP</b>	Support families as partners without making them the coordination system.	All professionals; coordinator ensures the family is not burdened.	Intake; after major changes; during crises; before/after transitions.	Reduced family burden; improved engagement and continuity; stronger trust and stability.	After meetings, send a short written summary with actions + named owners + deadlines.
<b>5) OUTCOME REVIEW &amp; ADJUSTMENT</b>	Ensure support improves participation/wellbeing (not just service delivered) and triggers timely adjustment.	Coordinator + involved professionals; understandable to families and, where possible, the young person.	Every review cycle; after major changes; when outcomes decline.	Earlier detection; targeted adjustments; fewer drop-offs; clearer participation gains.	Track fewer outcomes consistently; always end review with a decision and next review date.

# FINAL CONCLUSION

## From Fragmented Efforts to Coordinated Impact

The Manual for facilitation of social, medical and educational professionals in working with young people with disabilities was created in response to a reality shared across many European contexts: while inclusive values are widely endorsed, **inclusive practice still depends too often on individual effort rather than coordinated systems**. Young people with disabilities and SEN, and their families, continue to experience fragmented services, inconsistent accessibility, and abrupt transitions that undermine participation and wellbeing.

Through the Erasmus+ KA2 project "*I, You, We, They Can*", **Equality NGO**, in partnership with **IDEA – Ajuntament d'Alzira** and **Reflections on Europe**, brought together research, professional experience, and international learning to address these gaps in a practical way. The Manual reflects lessons from real service environments observed during study visits in North Macedonia, Spain and Poland, and translates them into **clear methods, shared tools and realistic coordination models**.

The strength of this Manual lies not in proposing ideal systems, but in defining **minimum standards that protect dignity and participation**, even where resources are limited. By focusing on communication access, shared planning, defined coordination roles, and regular outcome review, the Manual supports professionals and institutions to move from reactive responses to **planned, preventive and collaborative practice**.

Ultimately, this Manual is not an endpoint, but a **starting point for continuous improvement**. Its value depends on how it is used, adapted, reviewed and shared. When applied consistently, it can reduce family burden, improve professional cooperation, and strengthen participation and inclusion for young people across education, healthcare and social protection systems.

