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HUMAN RESOURCE  
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# **Support Systems for Families of Young Children with Disabilities: Review of Country Profiles**

## **Project Erasmus + M-POWER**

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## INTRODUCTION

### 1. Context and Significance of the Topic

The early years of a child's life (ages 0–7) represent a critical period for sensory, motor, cognitive, and social-emotional development. When a family is faced with a child's disability or developmental delay, they experience a state of high vulnerability, intense psycho-emotional stress, and the need to navigate complex institutional systems. The contemporary research and practice paradigm in Early Childhood Intervention (ECI) unequivocally demonstrates that a child's well-being is inextricably linked to the resilience and development opportunities provided by their family environment. Consequently, the focus of support today is shifting from the traditional, isolated medical model to a holistic, family-centered approach that recognizes parents as equal partners and active drivers of change.

The social inclusion of children with disabilities and the fight against poverty and social exclusion are among the leading priorities of the European Union, as embedded in initiatives such as the European Child Guarantee. However, despite shared European strategic goals, the reality across individual Member States reveals significant disparities in the development of delivered services, regulatory standards, and practices for both formal and informal parental support. In this context, the exchange of transnational experience becomes a vital tool for identifying working solutions and overcoming systemic gaps.

### 2. About the M-POWER Project

The project “Knowledge sharing partnership for empowerment of parents of children with disabilities through mutual learning” (M-POWER) was established as a direct response to the needs of families. Its mission is to empower parents of young children with developmental delays and disabilities by building sustainable parent-to-parent peer support mechanisms and enhancing parents' self-efficacy for independent living. The project's mission unites a multidisciplinary consortium of partner organizations with extensive academic and practical expertise: Karin Dom Foundation (Bulgaria), Babeş-Bolyai University (Romania), Soft Tulip Foundation (the Netherlands), and Fondazione Paideia (Italy).

The M-POWER methodology is grounded in the concept of mutual learning and experience exchange between parents and professionals. This innovative approach recognizes the unique strengths of families and creates synergies by combining the personal life experiences of parents with the professional competences, practical skills, and academic knowledge of specialists. The long-term objective of the project is to develop high-quality training tools and resources that

support the psycho-emotional well-being of parents, support them in their parenting role, and facilitate secure attachment and supportive adult-child relationships. By improving the qualifications of trainers, university tutors, practitioners, and parent leaders, the project aims to build capacity that enables transformation and change in both individuals and ECI systems at national and European levels.

### 3. Objectives and Scope of This Review

This review outlines the first practical steps and initial research undertaken by the partners to explore the support systems in their respective countries in detail. The primary objective of this joint review is to enable the partner organizations to gain an in-depth understanding of the specifics of each national system, to compare them, and to build a solid and secure foundation for all subsequent project activities based on the identified strengths and gaps. The detailed review and structured analysis of existing support systems also help derive resilience factors for families of young children with disabilities across the four partner countries.

To achieve these objectives, the process is structured into two consecutive and complementary components:

- **Stage 1 (This Review):** Review of national contexts and the development of detailed Country Profiles covering legal frameworks, funding mechanisms, the role of responsible institutions, and levels of accessibility to health, social, and educational services in Bulgaria, Romania, the Netherlands, and Italy. Identification of barriers and gaps: mapping geographical inequalities, shortage of qualified ECI professionals, institutional fragmentation, and delays in the early identification of developmental delays or disabilities.
- **Stage 2 (Surveys for Parents and Professionals):** Implementation of specialized survey research among parents and professionals to assess actual satisfaction with services, perceived community support, and specific family needs for psycho-emotional support.

This review of the systems (Stage 1) and the subsequent processing of the surveys (Stage 2) serve together as a shared, solid baseline for decision-making regarding the next steps of the project. The analysis of these two components will guide the partners in identifying and describing working good practices in each country in detail, and will provide the baseline for developing the specific training methodology and manuals for parents and professionals.

### 4. Target Audience and Further Application

As a strategic document, this review serves a dual purpose:

- **Internal Use (Consortium Guide):** It serves as a conceptual and empirical baseline for the next stages of the project. The findings regarding gaps and effective practices will be directly utilized in subsequent work packages to identify working support practices and to develop tailored training methodologies, manuals, and webinars adapted to the diverse cultural and socio-economic backgrounds of families.
- **External Dissemination (Advocacy Tool):** The review aims to raise awareness at local, national, and European levels. It will be actively disseminated among key stakeholders (policymakers, service providers, non-governmental organizations, academia) through social media, partner websites, and newsletters to stimulate systemic reforms and promote social inclusion.

## 5. Unified Structure of the Country Reviews

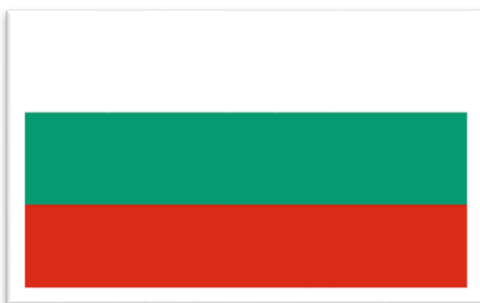
To ensure data comparability, the national review for each of the four countries is systematically organized into seven key analytical areas, presented in the following sections of this document:

1. National Context and Policy Framework – legislation, responsible authorities, and funding mechanisms.
2. Support for Early Childhood Intervention – referral mechanisms, eligibility criteria, and service delivery models.
3. Support for Parents and Families – care coordination, psychological counselling, training, and peer support groups.
4. Transition to School-Age Services – continuity between systems, educational inclusion, and transition challenges between different systems and stages of a child's life.
5. What Works Well – effective practices, innovative approaches, and professional staff training.
6. Challenges and Gaps – systemic gaps, barriers to access, and required additional resources.
7. Future Priorities and Development Needs – strategic directions for modernizing services and capacity.

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## *Bulgaria*

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## 1. Country Context and Policy Framework

Bulgaria, as part of the European Union, is directing its efforts towards developing policies for children and families in order to address the challenges of poverty and social exclusion and to improve their well-being.

Over the past 20 years, reforms undertaken in relation to children with special needs and their families have focused on preventing the abandonment of children in institutions, developing new services for children and families to support social inclusion and inclusive education, as well as training professionals.

One of the key policy documents that initiated these reforms is the National Strategy “Vision for the De-institutionalisation of Children in the Republic of Bulgaria” (2010). Its aim is to develop a system of community-based services that support families in raising children with special needs, including early intervention services. Supporting the implementation of this strategy is also the Social Inclusion Project, which was implemented by the Ministry of Labour and Social Policy (MLSP) in the period 2010–2015 with funding from the World Bank. The project supported Bulgaria’s efforts to develop and implement an integrated early childhood development policy. Within its framework, 64 centres were established across the country, providing integrated early childhood development services, including early childhood intervention, and specialists were trained.

In Bulgaria, state policy for supporting children with special needs and their families is regulated by several key national strategies, plans, and laws.

The main strategic documents are:

- National Strategy for Persons with Disabilities 2021–2030 – defines state policy, including access to services, social inclusion, early intervention, and family support.
- National Action Plan under the European Child Guarantee (2022–2030) – includes measures for children with disabilities, expansion of early intervention services, healthcare, education, and family support.
- National Programme for Improving Maternal and Child Health – includes early detection of disabilities, monitoring, and comprehensive care for premature children, children with disabilities and children at risk of developmental problems, as well as support for parents.

- National Strategy for Child and Adolescent Health and Paediatric Care 2030 – includes expansion of prenatal and neonatal screening programmes, developmental assessment and monitoring, referral and cooperation with social services for early intervention, development of health-social services, parent training, etc.

The legislative framework includes:

- Persons with Disabilities Act (DPA) – regulates individual needs assessment, financial support, assistive devices, and access to services.
- Social Services Act – regulates social services for children and families, including early intervention. The definition of “Early Intervention of Disabilities for Children” in the Act is: “specialised support for children with disabilities and children at risk of developmental delay up to 7 years of age and their families, which includes early identification of risks to child health and development, implementation of early intervention measures aimed at improving the condition and development of children, and building parenting skills.”
- Pre-school and School Education Act – guarantees inclusive education for children with special educational needs (SEN). The Act ensures early identification of difficulties, individual learning plans, resource support, and an adapted environment in order to enable full integration into state and municipal kindergartens and schools.

The responsible institutions for implementing these policies are the Ministry of Health, the Ministry of Labour and Social Policy, and the Ministry of Education and Science. Their respective structures carry out coordination, control, and implementation at regional and local levels. Municipalities are responsible for providing social services according to community needs; they may use state or municipal funding and delegate implementation to municipal structures or private (non-governmental) organizations.

## 2. Early Childhood Intervention Support: Access and Service Delivery

Early childhood intervention services in Bulgaria operate within the health and social care systems, and, in a broader sense, should also be considered in relation to the education system. Within the health system, early intervention services are provided by Centres for Comprehensive Services for Children with Disabilities and Chronic Conditions, as well as through medico-social care services for children (Children's Homes for Medico-Social Care). Within the social services sector, they are mainly delivered through Complexes for Social Services and specialised Early Intervention Centres.

According to the Social Services Act, early intervention covers children up to the age of seven. In this context, it is also important to take into account the role of the pre-school education system, which provides support for children with special needs. This enables better continuity between health, social, and educational measures during a critical period of child development.

Access to services is ensured through various referral mechanisms. Referrals may be made by medical professionals, Child Protection Departments, municipalities, as well as through self-referral by parents. However, access to services remains uneven across the country. Out of a total of 28 regional cities, mobile early intervention services are available in only a limited number of locations, which creates barriers for families living in smaller or more remote settlements.

Admission criteria vary depending on the system. In the health sector, access is primarily based on the available medical documentation of the child. In social services, an individual needs assessment is conducted to determine eligibility for inclusion. There is no regulatory requirement for the use of standardised developmental screening and assessment tools, although in practice some services apply such instruments, for example the Ages and Stages Questionnaires (ASQ).

No official national statistics are available regarding the coverage of early childhood intervention services. Some services are delivered within broader structures such as Complexes for Social Services or medical centres, which further complicates the monitoring of their actual reach. In

addition, up-to-date information on the functioning of the 64 early intervention centres established under the Social Inclusion Project is lacking.

In terms of system capacity, services are, in principle, open to all children with disabilities, developmental delays, or those at risk of such delays. In practice, however, there are significant limitations related to a shortage of qualified professionals, particularly those working with children aged 0–3 years. Not all services have multidisciplinary teams in place, and although rehabilitation services are guaranteed, they are often limited due to insufficient staffing.

An additional challenge is the limited availability of university programmes preparing specialists to work with very young children with special needs. As a result, professionals often rely on additional training courses to acquire the necessary competencies.

Funding for early childhood intervention services is provided from multiple sources, including the Ministry of Health, the Ministry of Labour and Social Policy, municipal budgets, European Union operational programmes, other project-based mechanisms, as well as private funding.

### 3. Support for Family and Parents

Support for parents and families varies depending on the child's condition and age. In the case of the birth of a child with a disability or special needs, support and coordination of the necessary medical services are regulated within the health system and include consultations with specialists and referrals to other, more specialised healthcare facilities relevant to the child's condition. If there is a risk of child abandonment in an institution, the maternity hospital notifies the Child Protection Department, which provides psychological and social support. However, most maternity wards in the country do not have a psychologist available to provide psychological support to families at the birth of a child with special needs or at risk of abandonment.

In Bulgaria, the general practitioner (GP) or paediatrician is responsible for monitoring child development during routine check-ups. This is done through observation and discussions with

parents rather than through the use of modern, standardized screening tools. In cases of developmental delay or risk, the GP may refer the child to another medical specialist or service. However, there is no clear care pathway for follow-up procedures after referral, nor is it systematically ensured that referrals result in a comprehensive assessment and an individualised plan to address the child's needs, as highlighted in the Situation Analysis of Services for Young Children with Developmental Difficulties and Disabilities in Bulgaria, prepared by UNICEF.

In nurseries and kindergartens, psychologists may provide consultation and refer parents to services or specialists. Kindergarten teachers apply a mandatory developmental screening for children at the age of three; after which, with parental consent, additional support may be offered to the child to assist the educational process. Resource centres, which are structures of the Ministry of Education supporting inclusive education, coordinate the development of needs assessments and individual support plans for the child. This coordination involves parents, professionals, organisations, and institutions relevant to the specific case.

Counselling and training for parents of children with special needs are primarily provided within social services. In some services, interventions are carried out jointly with both parent and child in group settings, allowing parents to learn intervention methods while also receiving peer support. Within medical services, parent education is usually limited to information specific to the child's health condition.

In Bulgaria, there are a number of parent-led non-governmental organisations established to support families of children with specific needs, such as families of premature infants, children with craniofacial anomalies, spina bifida and hydrocephalus, among others.

#### 4. Transition to School-Age Services

The transition from early childhood intervention services to the education system in Bulgaria is primarily regulated by the Pre-school and School Education Act, which guarantees every child's right of access to education. Compulsory pre-school education begins at the age of four, while compulsory school education starts at the age of seven.

Despite the existing regulatory framework, the transition between the two systems is not fully structured and depends to a significant extent on parental initiative and the interaction between different professionals. In cases where a child has received early intervention or therapeutic support services, professionals prepare an expert assessment of the child's condition and development. This document supports kindergarten and school teams in assessing educational needs and planning appropriate support.

Upon enrolment in kindergarten or school, the provision of additional personal development support is initiated at the parental request. An assessment of educational needs is carried out; the presence of special educational needs is determined; and an individual support plan is developed. There is no mechanism for the automatic provision of support in cases where parents do not submit such a request, which may result in delays in accessing necessary services.

A significant challenge in the transition process is also the lack of support services in nurseries, which cater to children aged 2 to 3 years and fall under the health system. In cases of developmental delay, nurseries do not provide specialised support but instead refer parents to external services, such as early intervention programmes or individual specialists. This creates a gap in support during a critical early stage of development.

After entry into the education system, support for children with special educational needs is provided in various forms: in mainstream kindergartens and schools through additional support, in specialised institutions, or in centres for special educational support. Regional centres supporting the inclusive education process play a key role by providing specialists (resource teachers, speech and language therapists, psychologists, etc.) Who works directly with children in educational settings.

During the transition from kindergarten to school, a certain degree of continuity is ensured through the preparation of documentation, including pedagogical profiles, reports from support teams, and recommendations for future work with the child. However, coordination between different stages and systems remains limited and is not formalised as a comprehensive mechanism for tracking the child's development.

Overall, the transition to school age in Bulgaria is characterised by the existence of individual elements of continuity, but a lack of a systematic and integrated approach that would ensure uninterrupted support for children with disabilities or those at risk of developmental delay.

## 5. Effective Practices and Innovative Approaches

In the field of early childhood intervention in Bulgaria, a number of effective practices can be identified, relating both to service delivery approaches and to the development of services and professional capacity.

One of the most significant effective practices is the implementation of a family-centred approach, in which intervention focuses not only on the child but also on the family as the child's primary developmental context. This approach positions parents as equal partners in the process, actively involved in decision-making and in setting the goals of support. By building parents' skills, knowledge, and confidence, more sustainable and effective support is achieved in the child's everyday environment. Although this model is well established in international practice, in Bulgaria it is still perceived as innovative and remains a challenge for professionals who have traditionally worked within an expert-driven approach.

Another key element is the interdisciplinary model of work, in which professionals from different fields (speech and language therapists, psychologists, physical therapists, and others) collaborate to achieve shared goals. This enables a more holistic understanding of the child's development and better coordination of interventions.

An additional effective practice is the provision of mobile services in the child's natural environment – such as the home, playground, or other everyday contexts. This approach supports the application of learned skills in real-life situations and increases family engagement.

Particularly important is the early reach of children aged 0–3 years, a critical period for brain development. During this stage, the foundations of sensory, motor, language, social-emotional, and cognitive development are laid, making early intervention highly impactful in the long term.

In Bulgaria, there are also concrete examples of the application of these approaches. These include early intervention services provided by the Karin Dom Foundation, as well as a home-visiting early childhood care and support model for young children and families, developed with UNICEF support and implemented in a number of municipalities. These initiatives introduce good practices such as working in natural environments, active parental involvement, and coordination between services.

Regarding professional training, Bulgaria has an established foundation for educating specialists in fields related to child development, rehabilitation, and work with children with special needs. University programmes provide the basic knowledge and skills that create conditions for working in various child and family support services.

At the same time, training specifically focused on early childhood intervention, particularly for the 0–3 age group and the application of a family-centred approach, is still developing. As a result, professionals often need to further build their competencies through additional training, practical experience, and participation in various initiatives.

In recent years, a number of trainings and projects have been implemented with the participation of organisations such as UNICEF and leading Bulgarian non-governmental organisations, contributing to the introduction of modern approaches into practice. These initiatives play an important role in strengthening professional capacity and promoting family-centred practice.

Despite this progress, opportunities for further development remain, particularly in expanding specialised training for work with very young children, addressing staff turnover in the sector, and creating more opportunities for continuing education, supervision, and professional support in practice.

## 6. Existing Challenges and Barriers

Over the past 20 years, Bulgaria has made significant progress in regulating and developing new services, as well as restructuring existing services, to support families of children with special needs. However, a number of challenges remain for families and professionals that need to be addressed by institutions.

### **Need for improved regulation of early childhood intervention services**

Early childhood intervention is regulated under the Social Services Act and is included in strategic documents and national plans and programmes. However, there is no unified service standard, and early childhood intervention is most often embedded as a combination of different activities within medical, social, or educational services. As a result, its overall conceptual framework is often lost.

The law defines a broad age range for early childhood intervention services for children with disabilities - 0 to 7 years - in order to ensure broader access. However, this shifts the focus away from the 0–3 age period, when intervention is most effective and families have the greatest need for support. Consequently, service providers supporting children with developmental difficulties have limited incentives to prioritise work with children aged 0–3. This also makes it more difficult to collect data and monitor service coverage.

### **Unequal access, service coverage, and professional capacity**

Access to early childhood intervention services varies significantly across regions. In smaller towns and rural areas, qualified professionals are often lacking, while in larger cities waiting times may be longer. As a result, parents either travel to larger urban centres to access services or seek private, paid services to support their child's development.

In Bulgaria, there is still a widespread tendency among both medical and non-medical professionals to advise parents to “wait and see” when a child shows developmental delays. This is partly based on the belief that children may outgrow delays, but also on the fact that professionals

such as speech and language therapists and psychologists primarily work with children older than 3–4 years. The lack of modern developmental screening tools used by paediatricians also hinders early identification of developmental delays.

In addition, the absence of standardised developmental screening tools used by general practitioners, paediatricians, and nurseries contributes to late referral to early childhood intervention services and missed opportunities to intervene during the critical 0–3 age period.

Regarding professional qualifications, recommendations have been developed for universities to expand their curricula in early child development and early childhood intervention. Some universities have already taken steps in this direction. In addition, private organisations offer courses and training focused on working with children aged 0–3 with special needs and on intervention approaches for specific conditions.

In nurseries and kindergartens, educators also need additional training to recognise early signs of developmental delays, support the inclusion of children with special needs in daily activities, use alternative and augmentative communication methods, structure the learning environment, and manage challenging behaviour.

### **Insufficient coordination of early childhood intervention services**

In Bulgaria, early childhood intervention services do not operate within a unified coordination system but rather through fragmented mechanisms that function partially and locally. Families are often left to navigate between medical professionals, social services, speech therapists, psychologists, and other specialists on their own. Services that offer multidisciplinary team support provide a significant advantage for families, as they enable coordinated, comprehensive support for the child in one setting.

In social services, social workers typically guide families through the system, supporting them in clarifying diagnoses, accessing financial and material resources, and managing transitions to other services, nurseries, kindergartens, or schools. Some social services have developed good cooperation practices with medical professionals and educational institutions, which facilitates coordination.

## **Insufficient support for parents**

Feedback from parents highlights a strong need for psychological support at the maternity ward level when a child with special needs, including premature infants, is born. At this stage, it is also important to provide referrals not only to services offering medical care for the child but also to services offering psychological support for parents.

A good practice in some social services is the organisation of group psychological support and peer support groups for parents, facilitated by a psychologist.

In some nurseries and kindergartens, psychologists may provide consultation to parents regarding the child's condition; however, their primary role is not to provide psychological support to parents. The main focus of these institutions is child-centred support, and insufficient attention is given to building a partnership with parents or addressing their psychological needs.

In Bulgaria, there are various formal and informal parent communities organised around specific conditions or diagnoses. Within these organizations, parents share experiences and provide mutual support. However, in many cases, parents lack training in supportive communication and counselling-related skills, which may lead to burnout. There is a need for resources and/or training in peer-to-peer parental support.

## **7. Future Priorities and Development Needs**

### **A unified system for early childhood intervention**

In Bulgaria, there is a need to establish a unified system for early childhood intervention with a strong focus on children aged 0–3 years. Such a system should:

- support the process of early identification of developmental delays and special needs, including through the regulation of the use of standardised, up-to-date screening tools by paediatricians or other professionals at key ages and developmental stages;

- establish a unified standard to be followed by different service providers;
- regulate coordination between institutions, professionals, and services;
- place a strong emphasis on psychological support for families and a family-centred approach;
- ensure good accessibility and coverage of services, including mobile services, particularly for families in smaller and remote settlements;
- support the collection of service data to inform planning and evaluation processes.

### **Training and professional capacity building**

- Development of university programmes to include a stronger focus on working with children with special needs aged 0–3 years, as well as on the provision of early childhood intervention services;
- Provision of practice-oriented training for teachers and professionals on inclusive education for children with special needs.

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## *Romania*



## 1. Country Context and Policy Framework

Concerning national **policy and the legislative framework**, in Romania there are core laws regulating services for children with disabilities and special needs.

### *For social protection and disability:*

**Child Protection Law no. 272/2004**, which has been updated several times, defines child protection services, early intervention, and family support.

**Law no. 448/2006 on the protection and promotion of the rights of persons with disabilities** (core disability law; defines benefits, services, and institutional responsibilities).

**Social Assistance Law no. 292/2011** – establishes the national social services system and the responsibilities of central and local authorities. The Early Childhood Education and Care system became more affordable over the past five years. Public ECEC sees parents paying only a monthly contribution for food, and the facility establishes its amount following consultation with the child's parents. On average, the cost of ECEC for two children fell from 13 per cent of the average family wage in 2018 to 9 per cent in 2022– regardless of family income and single parenthood status.

**Government Decision 566/2022** – regulates the organization and operation of nurseries (0–3 years).

### *For education:*

**Education Law no. 198/2023** (previously Law 1/2011) – guarantees inclusive education and special education services.

Methodological orders regulate enrollment, the curriculum, and special education services.

### *For health:*

Ministry of Health regulations provide preventive and pediatric care, community nursing, and rehabilitation standards.

***Integrated services framework*** - Romania has developed the **Minimum Package of Services (MPS)** and EU Child Guarantee Action Plan to ensure integrated health, education, and social support at community level.

### **National strategies (current strategic framework)**

1. National Strategy for the Protection and Promotion of Children’s Rights 2022–2027 which has several objectives, including providing equal access to public services for all children, increased access to early education (0–3 years), the prevention of family separation, decreases in infant mortality and improved health, and social and educational inclusion of vulnerable children, including children with disabilities.

2. National Action Plan for the European Child Guarantee (2023–2030) having has several commitments, such as ensuring access to healthcare, early childhood education and care, social services and inclusive education, prioritizing children with disabilities as a key target group, and €19 billion investment from EU and national sources. The Child Guarantee provides a unique opportunity to invest in accessible and quality services to fight poverty and social exclusion, and to prioritize urgent measures for vulnerable children, aiming to create social structures and services that will improve the living standards of children in Romania.

### **Responsible authorities**

Romania’s system is **multi-level and decentralized**, with responsibilities shared between national ministries, county authorities, and municipalities.

**The National level, authorities** are represented by the *Ministry of Labour, Family, Youth and Social Solidarity* having some key functions: national policy for social services and disability, oversight of disability benefits and social assistance, and coordination of the National Authority for Child Rights Protection and Adoption.

*The National Authority for Child Rights Protection and Adoption* is responsible for child protection policies, oversight of DGASPC (county child protection services), early intervention, and family support programs.

The *Ministry of Education* is responsible for ensuring inclusive education, special education schools, and support teachers, for the oversight of early childhood education services, and county-level specialized structures.

The *Ministry of Health* is responsible for preventive care, screening, and rehabilitation services, primary healthcare via family doctors and community nurses.

**The County-level authorities** represented by DGASPC – General Directorate for Social Assistance and Child Protection (Direcția Generală de Asistență Socială și Protecția Copilului), the core operational authority for children with disabilities, are responsible for disability assessment commissions, early intervention and rehabilitation services, case management, day centers and therapy centers, foster care, and protection services. DGASPC operates under county councils and national legislation.

The local (municipality/commune) authorities.

Municipalities and communes are legally responsible for local social services, community health nurses, early childhood services, integrated community centers, and local teams that often include social workers, community nurses, a school mediator, and a psychologist or counsellor.

A range of national screening programs across multiple health domains have been established under the framework of the Ministry of Health's National Health Programs, which include priority public health initiatives such as maternal and child health, chronic disease prevention, and improved access to preventive services.

Within the context of early childhood, neonatal screening currently includes systematic testing for phenylketonuria and congenital hypothyroidism, both of which are part of the national metabolic screening panel, funded and coordinated at a national level.

Newborns undergo hearing screening via otoacoustic emissions and are monitored for several other risk conditions, such as retinopathy of prematurity, reflecting a broader commitment to early detection of conditions that affect development.

## 2. Early Childhood Intervention Support: Access and Service Delivery

In Romania, early childhood services for children with disabilities are provided through an intersectoral system that includes medical, social, and educational services, with increasing emphasis on early screening and early intervention. Research and professional practice highlight that early intervention significantly improves developmental outcomes, school readiness, and social inclusion. Services typically involve multidisciplinary assessment and therapy, that is *developmental screening and early diagnosis* (motor, cognitive, and speech), *therapies* such as physiotherapy, speech and language therapy, occupational therapy, and sensory stimulation. *Home-based services*— specialized teams may visit the child’s home for evaluation and therapy if transport is difficult, provide *family support and education* to build parental competence in supporting the child’s development.

### Referral pathways: who can refer a child to early intervention services

Romania uses a **multi-entry referral system**, meaning children can be identified and referred through the health, social, or education sectors.

#### *Health sector referral* (most common entry point)

Professionals who can refer are the family doctor, the pediatrician, the neonatologist or maternity hospital staff, the neurologist or the community nurse. Hospitals and pediatric units are expected to provide **early identification, counseling, and referral after diagnosis or suspicion of disability**. The process consists of screening at birth, routine checkups, or developmental monitoring; if delay or disability is suspected, a referral to a specialist and DGASPC - General Directorate for Social Assistance and Child Protection follows, along with a referral to rehabilitation and therapy services.

#### *Social protection referral* (DGASPC and municipal social services)

Professionals who can refer are social workers (municipality or DGASPC), community social workers, case managers, and child protection professionals. Romania's integrated Minimum Package of Services relies on social workers and community nurses conducting outreach, home visits, and identifying children needing support early.

Referral pathways include direct referral to DGASPC disability assessment commission, referral to early intervention centers, and referral to rehabilitation services or social programs.

#### *Education sector referral*

Professionals who can refer are kindergarten teachers, early education staff, school psychologists, and school counselors. These professionals identify developmental delays and coordinate referrals to health or social services.

#### *Parents and caregivers (self-referral)*

Parents can directly access family doctors, pediatric specialists, DGASPC disability evaluation commissions, and therapy centers (public or NGO).

#### *Community-based integrated service teams*

Under Romania's integrated community model, referral may originate from a community nurse, social worker, school mediator, or integrated community centers. These multidisciplinary teams identify vulnerable children and connect them to services.

#### ***Eligibility criteria for early childhood intervention***

Eligibility generally falls into three categories:

1) Medical/developmental eligibility means children aged 0-6 with diagnosed disabilities, developmental delays, chronic medical conditions, neurological conditions, sensory impairments, genetic syndromes, prematurity, or high-risk births. Romania defines disability as a long-term physical, mental, intellectual, or sensory impairment that affects participation.

2) Official disability certification (important for full services and benefits)

Assessment is conducted by the County disability assessment commission, certification including disability category, severity level, and eligibility for therapy services, disability allowance, personal assistant support, and special education support.

### 3) At-risk or vulnerable children (without formal disability diagnosis)

Children may still receive services if they are developmentally delayed, socially vulnerable, living in poverty, premature infants, and institutionalized or at risk of separation. Integrated services specifically target vulnerable groups, including children with disabilities and children in rural areas.

#### Qualified personnel involved in early childhood intervention

Romania's early intervention workforce includes health professionals - pediatricians, neurologists, physiotherapists, speech therapists, nurses, and rehabilitation physicians; social sector professionals - social workers, case managers, child protection specialists, and family counselors; education professionals - special education teachers, psychologists, kindergarten teachers, and school counselors; community workforce - community nurses, social workers, and school mediators. All these professionals provide early identification and referral.

Concerning access to services, there are some strengths, meaning multiple referral pathways, legal entitlement to services (children with disabilities are entitled to therapy services, disability benefits, inclusive education, and social services), integrated community model expanded nationally.

The major barriers encountered are:

- geographic inequality - early intervention services are often located in county capitals, making access difficult for rural families due to transportation barriers.
- a limited number of specialists - speech therapists, occupational therapists, psychologists, and early intervention specialists, especially in rural areas.
- services divided between the health system, the social protection system, and the educational system; co-ordination is still inconsistent, while improving.
- long waiting times in some counties - families often rely on private therapy due to limited public capacity.
- low awareness among parents - some families do not know that services exist; they do not know how to access disability certification; and some families often deny existing problems, delaying seeking intervention.

#### **Medical Services (Health & Rehabilitation)**

Medical support for infants/toddlers with disabilities and developmental risk is provided through regular Pediatric and Specialist Care. Family pediatricians monitor child development and refer to

specialists when delays are suspected. Specialists (neurology, developmental pediatrics, ophthalmology, audiology, speech, physical, and occupational therapy) work with children when there are risk factors such as premature birth or sensory impairments. Therapeutic Services (often integrated with social services) consist of rehabilitation through kinetotherapy (physiotherapy), speech therapy, and psychological support, is typically part of local community services. Some centers integrate social and medical services, providing therapy on-site to support children's development (<https://www.unicef.org/romania/ro>).

**Social Services (Community and Family Support)** are coordinated by General Departments of Social Assistance and Child Protection at the county level, including day centers providing therapy and social support. These include multidisciplinary teams (medical, social, and early education specialists) working directly in communities to reduce barriers to service access for vulnerable families— including children with special needs. EU funds are also being invested in daycare services that include psychological and rehabilitation therapies for children with disabilities. (PNRR, Inclusion & Social Dignity Programme 2021–2027).

### **Educational Services**

Children from birth to 3 are typically not in compulsory education, but there are support pathways. Romania's system includes ante-preschool services for children from infancy to age 3, including nurseries, preschool, and early education for children aged 2.5–3 until 6-7 years of age. Early educational or pre-school support programs may be offered, especially where disability or developmental delays are identified. Educational services often come with speech therapy and developmental interventions to support readiness for formal preschool.

Schools must offer equal access and adapt instruction to children's special educational needs, either in mainstream classrooms with support (support teachers, individualized plans, adapted materials) or in special schools/programs depending on assessment and needs.

The County Centers for Educational Resources and Assistance (CJRAE) and the Bucharest Municipal Center for Educational Resources and Assistance (CMBRAE) evaluate and guide educational support for children with special educational needs/disabilities. These centers coordinate services such as evaluation, speech support, school counseling, and educational support for children integrated into kindergarten/school.

Based on evaluations (school readiness and learning profiles), individualized plans are developed to ensure children receive appropriate teaching support, therapeutic assistance, and adaptations within their educational setting.

### 3. Support for Family and Parents

#### *1. National Parenting Education and Support Initiatives*

**The national parenting education programme** developed by UNICEF Romania in partnership with the Ministry of Education and other ministries aims to make **parenting education widely accessible**, helping caregivers build skills for nurturing children’s development from birth onward.

#### *Early Childhood – Play, Learning and Parenting Hubs*

UNICEF helped set up **Play, Learning and Parenting Hubs** across several Romanian cities, including **Cluj-Napoca**. These hubs support young children’s development (birth to 6 years) and offer spaces **where parents and children can interact, play, learn, and socialize**, indirectly supporting parenting skills.

#### *Family Support at Maternity Level*

In Romania, maternity and family support policies form a relatively comprehensive framework that accompanies women and families throughout the entire maternity process: during pregnancy, at childbirth, and after the child’s birth. This form of protection has its roots in labour law, social insurance regulations, and gender equality legislation.

#### *2. Local Services Offering Counseling and Parent Support*

**Parent and Child Resource Center** (Cluj-Napoca): Provides information, parent education, needs assessment, guidance, and referrals for families at risk or needing support.

Similar **Centers for counseling and support for parents and children** exist in various places through social services — aiming to help families navigate psychosocial challenges and improve caregiving skills.

### *3. Group Support and Peer Networking*

#### **Parent Support Groups & Peer Networks**

Many local centers and NGOs facilitate **group sessions** or **parenting classes** where caregivers share experiences, receive guidance, and build peer networks — valuable for emotional support and practical problem-solving. Some projects include monthly support groups specifically for parents (especially mothers), where members exchange information and receive psychological support.

#### *4. Specialized Support & Referrals*

The Romanian social support framework (including social services and local authorities) enables case assessment and referral to appropriate specialists (psychologists, social workers, etc.) depending on family needs. Parents experiencing challenges (risk of child–family separation) can be connected with integrated services that include parent education and counseling.

#### **Parents of Very Young Children (0–3 years)**

Programs specifically tailored for **0–3 years** tend to be less structured nationwide. However, parenting education—including information on **early care and development**—is part of broader national programs. Local health clinics, social services, and NGOs often offer **prenatal and postnatal support**, monitoring, and advice (especially in urban settings), though availability varies by region.

On the other hand, in Romania, there is a form of support during pregnancy, meaning **workplace protection, health, and safety** (employers are legally required to assess workplace risks, adapt working conditions, modify job duties, or temporarily reassign the employee to a safer position; women are entitled to maternity risk leave of up to 120 calendar days). There is also **protection against discrimination and dismissal** (enhanced legal protection; dismissal during pregnancy is forbidden; informal discrimination may persist in practice and **financial and community-level support** during pregnancy (pregnant women may benefit from local or municipal support schemes, such as vouchers for prenatal medical services). The government also offers support at the same time during childbirth and maternity leave: 18 weeks of maternity leave (the prenatal and postnatal periods, at least 42 days after childbirth, parental leave for child-rearing up to 2 years, extended to 3 years if the child has a disability), financial support during maternity leave (maternity allowance equal to 85% of their average gross income from the previous 12 months) and job protection and

employment continuity (employers are required to reinstate returning employees to their previous position; dismissal during maternity leave is strictly prohibited).

### *Support after childbirth - parental and family-centred measures*

Parental leave for childcare (one of the longest periods in Europe), gender equality, and father involvement (fathers are entitled to paternity leave of five working days, extendable to 15 days if the father completes a certified infant-care course. Paternity leave is paid at 100% of earnings and can be taken within the first eight weeks after birth). There are also incentives for returning to work (insertion incentive benefit) and breastfeeding support and flexible working arrangements (up to 12 months, mothers are entitled to two paid breastfeeding breaks per day or, alternatively, a reduction of the working day by two hours with full pay).

## 4. Transition to School-Age Services

The transition from ECI to school-age services includes, on one hand, moving from home-based/**therapeutic support to a more structured education**, and on the other hand, moving from **individualized early intervention plans to a curriculum-based learning approach**. That means an inclusion in **kindergarten (ages 3–6) and primary school (6+)**

A **successful transition** should ensure continuity of developmental support, close collaboration between professionals, family involvement, and individual transition planning. European policy recommends strong cooperation between **ECEC (Early Childhood Education and Care) and primary schools**, and joint work with parents and counselling services.

Regarding transition, Romania encounters a few challenges, such as that transition planning is not systematically implemented and individualized transition plans are often missing. At the same time, we can speak about weak inter-institutional collaboration, meaning limited coordination between ECI providers, kindergartens, and schools; transition often depends on informal cooperation. School enrollment can also be delayed or hindered by a difficult transition from ECI to ECEC services, a shortage of specialized staff in early intervention and inclusive education, particularly in rural areas. Therefore, we can mention some cases of inequity in access, lower participation in

early education among rural children, Roma communities, and children from disadvantaged backgrounds.

Considering the transition from kindergarten to primary school, it includes adaptation to a formal schooling structure, increased academic expectations, and reduced therapeutic support (in many cases), involving risks such as a loss of continuity in support services and poor communication between preschool and school staff.

Nevertheless, Romania has introduced some reforms. For instance, nurseries have moved under the Ministry of Education and Research, there is a unified curriculum across the early years. In recent years, the Romanian government has embarked on a range of reforms to raise participation in ECEC, expand coverage, and enhance the quality of services. It has progressively transitioned to an integrated system, lowered the age of compulsory education, and devoted substantial funds from the National Recovery and Resilience Plan (PNRR) to new facilities and staff training. There is also a better intersectoral coordination framework, meaning national committees coordinating health, education, and social services. A well-functioning transition system would significantly improve school readiness, educational outcomes, and long-term social inclusion.

## 5. Effective Practices and Innovative Approaches

Many ECI initiatives are implemented by NGOs and partnerships with universities. As mentioned before, key systemic challenges still include uneven access between urban and rural areas, a limited number of trained specialists, and fragmented services between the health, education, and social sectors. Projects and NGOs often fill these gaps by developing multidisciplinary and family-centred models. A major milestone was the recognition of early intervention services in Romanian legislation in 2022, partly due to advocacy from organizations working with children with sensory disabilities.

The most successful programs in Romania tend to share several evidence-based elements. That is a multidisciplinary team (pediatricians, neurologists, psychologists, physiotherapists, occupational

therapists, speech therapists, social workers) that assesses children and devises individual intervention plans developed together with parents. Then we consider the family-centered approach, in which effective programs treat parents as active partners, not just service recipients. Common practices include parent training and counseling, family support groups, guidance on home-based developmental activities, and information about rights and services. Programs also aim to reduce child abandonment and institutionalization by strengthening family capacity.

One other element concerns community-based early identification, including community screening and referral systems: screening by primary healthcare providers, referrals from early childhood educators, home visits by social workers, and collaboration with community actors. These help identify children before school age, which is critical for developmental outcomes.

Once assessed, children receive tailored interventions, including speech therapy, physiotherapy, occupational therapy, psychological therapy, and sensory stimulation. Programs often combine center-based therapy with home-based exercises to reinforce progress.

### Innovative Approaches Emerging in Romania

#### 1) Multi-sensory Stimulation and Specialized Disability Programs

Some initiatives focus on specific disabilities: programs for deafblindness and sensory disabilities include multi-sensory stimulation, functional visual training, and perceptual-auditory education. These programs have supported hundreds of children and families across multiple cities. One of the examples supporting this initiative is the development by Sense International Romania, together with the School Center for Inclusive Education "Cristal" Oradea, the Special Technological High-School "Vasile Pavelcu" Iași and the School Center for Inclusive Education "Constantin Pufan" Timișoara of the guide *First Steps: A Guide for Parents of Children with Deafblindness and Sensory Disabilities* (2024). The material was developed with the help of over 70 parents from Iași, Oradea and Timișoara, who shared their experience, so that it would be as useful as possible for parents at the beginning of the journey.

#### 2) Therapy Diversity (creative and alternative therapies)

Innovative programs combine traditional therapy with creative interventions: music therapy, art therapy, aqua therapy, animal-assisted therapy. These approaches help children improve motor, emotional, and social skills while increasing engagement.

#### 3) Digital and Technology-Supported Therapies

A significant part of Romanian research addresses parent-mediated digital interventions, since for infants and toddlers, therapies are usually implemented through caregivers rather than directly with the child. Some Romanian research is focused on interactive digital tools for preschoolers, which can indirectly support therapy for developmental delays. Research from Babeş-Bolyai University (Cluj-Napoca) proposed human-centered digital applications to support early learning and digital skill development. Although not purely therapeutic, such systems can be used in speech therapy, developmental stimulation, or cognitive training.

#### 4) Professional Training

Effective strategies include: *interdisciplinary training programs* for training professionals from multiple sectors, such as health, social services, and early childhood education; *coaching and mentoring models* - some programs train practitioners through supervised practice, coaching from experienced specialists, and case consultations. This improves practical skills beyond academic training. Early intervention projects often train: family doctors, nurses, preschool educators, social workers. This improves early detection and referral.

Concerning possible innovative approaches, NGO early intervention centers often offer good practices, including developmental assessment, therapy services, parental counseling, and community awareness activities. Romanian universities play an important role in developing evidence-based practices.

Many early intervention services involve teams composed of pediatricians, neurologists, psychologists, physiotherapists, speech and language therapists, occupational therapists, and social workers. These professionals collaborate to conduct comprehensive assessments and develop individualized intervention plans. A strong emphasis is placed on family participation, where parents are actively involved in therapy planning, receive guidance for home-based activities, and participate in counseling and support groups. This approach strengthens parental competence and contributes to better developmental outcomes for children.

Another effective element is the community-based identification and referral system. Developmental screening conducted by family doctors, pediatricians, early childhood educators, and community health workers helps identify developmental risks at an early stage. Home visits by community nurses and social workers, especially in vulnerable communities, further support early detection and referral to specialized services.

NGO-led early intervention programs play a significant role in Romania by complementing public services and introducing innovative practices. Organizations such as Sense International Romania have developed multidisciplinary early intervention programs, mobile therapy teams, and parent training initiatives. These programs often serve as pilot models for family-centered care and community-based intervention.

Innovative approaches are also emerging through specialized programs for children with sensory disabilities, including multisensory stimulation, functional vision training, and auditory-perceptual development programs. For example, collaboration between specialized schools and organizations has led to the development of practical resources for families, such as the guide *First Steps: A Guide for Parents of Children with Deafblindness and Sensory Disabilities*.

In addition, some centers are introducing creative and complementary therapies, including music therapy, art therapy, aquatic therapy, and animal-assisted therapy. These approaches aim to improve children's motor, emotional, and social development while increasing engagement and motivation during therapy.

Digital and technology-supported interventions represent another emerging innovation. Recent research conducted by Romanian universities explores parent-mediated digital tools and applications that support early learning, communication development, and cognitive stimulation in young children. These tools can complement traditional therapy and support parent-child interaction.

Overall, the combination of multidisciplinary services, family-centered approaches, community-based identification, NGO innovation, and growing professional training initiatives represents a strong foundation for the development of early childhood intervention services in Romania.

## 6. Existing Challenges and Barriers

Despite important progress in the development of early childhood intervention and support services for children with disabilities in Romania, several systemic challenges remain.

One of the most significant challenges is unequal access to services between urban and rural areas. Early intervention centers, rehabilitation services, and specialized professionals are often concentrated in large cities or county capitals. Families living in rural or remote areas frequently face difficulties accessing services due to transportation barriers, limited infrastructure, and the absence of local specialists. As a result, some children receive interventions later than recommended or depend on private services, which may not be financially accessible to all families.

Another major challenge is the limited availability of specialized professionals. There is a shortage of speech and language therapists, occupational therapists, physiotherapists, psychologists, and early intervention specialists, particularly in smaller communities. This shortage contributes to long waiting times for assessments and therapy and can delay the initiation of early intervention services. The fragmentation of services between the health, social protection, and education sectors also represents a barrier. Although Romania has made efforts to develop integrated community services, coordination between institutions is not always consistent. Families often need to navigate complex administrative procedures and interact with multiple institutions to obtain disability certification, therapy services, educational support, and social benefits.

Another difficulty is related to **limited awareness among parents and communities about early developmental difficulties and available services**. Some families may not recognize early signs of developmental delay or may postpone seeking professional support due to stigma, lack of information, or fear of diagnosis. Increasing public awareness and improving communication about early intervention services remain important priorities.

In addition, **financial and logistical barriers** can affect access to services. While certain therapies are available through public services, the capacity of public centers is limited, leading many families to rely on private therapy services. These services may represent a significant financial burden, especially for families with lower incomes.

To address these challenges, several additional resources and improvements are needed. These include expanding early intervention services in rural and underserved areas, increasing the number of trained specialists, strengthening interinstitutional coordination, and developing more integrated community-based service models. It is also important to invest in professional training programs, parent education initiatives, and public awareness campaigns about early identification and intervention.

Strengthening these areas would help ensure that all children with disabilities or developmental risks in Romania have timely access to high-quality early intervention services and support for their families.

## 7. Future Priorities and Development Needs

In the coming years, the development of early childhood intervention services in Romania should focus on strengthening integrated, accessible, and family-centered support systems for children with disabilities and developmental risks.

One important priority is the **expansion of early intervention services** at the community level, particularly in rural and underserved areas. Increasing the availability of multidisciplinary services outside major urban centers would help ensure that all children can benefit from early detection and intervention regardless of their place of residence. This includes the development of additional community-based early intervention centers and mobile multidisciplinary teams capable of reaching vulnerable families.

Another key priority is **strengthening coordination between health, education, and social protection systems**. Although each sector provides valuable services, more effective collaboration and shared referral pathways are needed to ensure continuity of care. Developing integrated case management systems and strengthening multidisciplinary collaboration would make services easier to navigate.

A further development priority concerns **increasing the number and capacity of trained professionals** working in early childhood intervention. Expanding university training programs, professional development courses, and interdisciplinary training initiatives would help address the current shortage of specialists, such as speech therapists, occupational therapists, psychologists, and early intervention specialists.

Romania could also benefit from **strengthening early screening and monitoring systems**, ensuring that developmental screening is systematically implemented and that referral pathways to intervention services are clear and accessible. Expanding neonatal screening programs and

increasing awareness among healthcare providers and families would support earlier identification of developmental risks.

Another important area of development is the **enhancement of family-centered services**. Parents and caregivers should continue to be recognized as key partners in the intervention process. Expanding parent training programs, counseling services, and peer-support networks can empower families and improve long-term developmental outcomes for children.

Finally, continued **investment in research, innovation, and digital tools for early intervention** represents a promising direction. Universities and research institutions in Romania already contribute to the development of evidence-based practices and new intervention approaches. Strengthening partnerships between universities, NGOs, and public institutions can support innovation, professional training, and the dissemination of good practices at the national level.

By addressing these priorities, Romania can continue to strengthen its early childhood intervention system and ensure that children with disabilities or developmental risks receive timely, coordinated, and high-quality support during the most critical years of development.

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## *The Netherlands*

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## 1. Country Context and Policy Framework

In the Netherlands, support for young children with special needs and/or disabilities is legally embedded in a decentralized system. There is not one single law covering all integrated early childhood intervention; instead, care is distributed across 4 main laws that together form the safety net for vulnerable children and their families. Namely:

1) Youth Act (Jeugdwet):

Since 2015, municipalities have been responsible for all forms of youth care. This includes prevention, diagnostics, treatment, and support for developmental problems, as well as residential care. The aim is to strengthen the family's own capabilities.

2) Social Support Act (Wet maatschappelijke ondersteuning; Wmo):

This law is implemented by municipalities and is relevant for young children when there is a need for home adaptations or assistive devices (such as adapted strollers) to promote the child's participation.

3) Long-term Care Act (Wet langdurige zorg; Wlz):

This law is intended for children with a permanent need for 24 hour care or continuous supervision, often in cases of very severe intellectual or multiple disabilities. Its implementation lies with care offices, not municipalities.

4) Health Insurance Act (Zorgverzekeringswet; Zvw):

Medical care, such as treatment by a pediatrician, physiotherapy, speech therapy, or care for sensory impairments, falls under health insurance.

The responsible authorities are the Ministries of Health, Welfare and Sport (VWS) and Education, Culture and Science (OCW) at the national level, while municipalities are responsible for the local implementation of youth care. Funding is provided through central government contributions to municipalities and premium revenues from health insurers.

## 2. Early Childhood Intervention Support: Access and Service Delivery

Integrated early childhood intervention in the Netherlands is aimed at early detection and a multidisciplinary approach.

### Referrals and access:

Access to specialized care usually takes place via the child health clinic (youth health care), which systematically monitors every child in the Netherlands from 0 to 4 years of age. Professionals such as the youth doctor or nurse identify developmental delays. In addition, the general practitioner, the paediatrician, or the municipal neighbourhood team can directly refer to specialized youth care.

### Eligibility criteria:

There is no strict diagnostic requirement for light support (under the Youth Act), but for more intensive trajectories or long-term care under the Wlz, an independent needs assessment decision (e.g., by the CIZ) is required.

### Service delivery model:

Care is generally organized in Medical Daycare Centres for Children (MKD) or Child Service Centres (KDC). Here, multidisciplinary teams consisting of special education specialists, psychologists, physiotherapists, and speech therapists work together on the child's developmental plan. In addition, home-based support is often provided to assist parents in the child's natural environment.

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### 3. Support for Family and Parents

In the Netherlands, the parent is seen as an equal partner in care. Support is aimed not only at the child, but at the entire family system.

#### Care coordination:

Parents can receive support from an independent client supporter or a case manager from the municipal neighbourhood team to navigate the often complex pathway through the different laws (Youth Act, Wlz, Zvw).

#### Parent training and guidance:

Organizations such as Cordaan offer specific programs, such as training in parental sensitivity and coping with ‘chronic grief’. The aim is to empower parents and strengthen their resilience.

#### Contact with peers / support groups:

Informal networks play a crucial role. In Amsterdam, for example, a successful mothers’ network has been established, supported by Cordaan. This network, run by mothers themselves, provides emotional support and practical information exchange in their own language and neighbourhood. Such networks help parents to normalize their lives and bridge the gap between professional care and the home situation.

### 4. Transition to School-Age Services

Once a child turns 4, they fall under the ‘Compulsory Education Act’ and the ‘Primary Education Act’.

### Transition to school

Consultation takes place between the preschool provision (such as a KDC or playgroup) and the primary school. In this phase, diagnostic data are shared. The aim is to ensure continuity of care and to prevent regression in development.

### Cooperation between educational institutions:

Regional partnerships assess whether a child needs additional support in a mainstream school or whether referral to Special Primary Education (SBO) or Special Education (SO) is necessary.

There are 3 possible educational pathways:

- 1) **Mainstream primary education:** Inclusion in a regular school, possibly with additional ambulatory support or an individual development perspective (OPP).
- 2) **Special primary education (SBO):** For children with learning or behavioural problems who require more structure, but who still follow the regular curriculum in an adapted form.
- 3) **Special education (SO):** Clustered expertise for children with significant support needs in the areas of intellectual, physical, or sensory disabilities, or severe behavioural problems.

The regional partnership issues and, if necessary, an admissibility statement (toelaatbaarheidsverklaring; TLV), which is required for funding and placement in Special primary education (S)BO or Special education SO. For children who need medical care or intensive guidance at school, coordination between the school (education) and the municipality or health insurer must be properly arranged. Responsibility for organizing this additional support at school lies with the neighbourhood team worker. In close cooperation with the parents and the school, the neighbourhood team worker ensures that the necessary assistance and support are concretely arranged and facilitated.

## 5. Effective Practices and Innovative Approaches

Early Childhood Intervention in the Netherlands focuses on the child's social context.

A number of success factors are:

### Early detection

One of the foundations of Dutch success is the structure of Youth Health Care (JGZ). Through child health clinics, almost every child aged 0 to 4 is systematically monitored. The use of standardized monitoring tools by youth doctors and nurses ensures that developmental deviations or signs of a disability are detected at a very early stage. This proactive screening forms the essential first step toward timely intervention, which significantly improves the long-term prognosis.

### Integrated, family-centred approach

The Netherlands has shifted from a purely medical focus on the child to a systemic approach to the family. Under the motto “one family, one plan, one coordinator,” the child’s disability is not treated in isolation, but is viewed within the context of the family situation. This approach recognizes that the child’s well-being is directly connected to the resilience of the parents and siblings. By offering tailored support that also addresses the psychosocial needs of the family, a more stable foundation is created for the child’s development.

Care providers such as Pameijer provide family support for families facing parenting or household-related challenges. The focus is on strengthening the child’s home environment by supporting parents, caregivers, and their wider network. Key principles include self-direction and the reinforcement of self- and co-reliance, building on the strengths of both the child and the family system. This support can be offered alongside specialised treatment in a day treatment centre (KDC), with close cooperation between family support workers, professionals, and the wider network around the child. In addition, an evidence-based method recognised by the Netherlands Youth Institute (NJI) is working along a solution-focused approach, which emphasises identifying existing strengths and practical solutions within the family system rather than focusing primarily on problems.

### Informal networks

An innovative strength in the Dutch care landscape is the close connection between formal care institutions and informal self-help groups. A good example is the mothers’ network in Amsterdam, established by and supported by the care organization Cordaan. This network acts as a bridge between the professional world and the everyday lives of families, often with diverse cultural backgrounds. This integration promotes mutual knowledge sharing: professionals learn about

culturally sensitive needs, while parents find support among peers (peer support). This lowers the threshold to access care and strengthens social cohesion in the neighbourhood.

### Learning through play (FloorPlay)

FloorPlay is a treatment method for young children who need extra attention in their development, for example due to an intellectual disability or a disorder within the autism spectrum.

FloorPlay is based on six developmental milestones, both in cognitive and socio-emotional domains. Together with parents, it is assessed which milestones are not yet sufficiently developed and how these can be worked on through play. Parents gain insight into the different developmental stages of their child, the (biological) differences between children and parents/caregivers, and the relationship between caregiver and child.

First, an inventory is made of the parents' questions and what is needed to start the treatment, either at home or at one of the locations. During play sessions, recordings are made and later discussed with the parents. Based on this, a so-called play plan is drawn up, which serves as the basis for exercises in different forms of play.

Through FloorPlay, parents learn how to stimulate their child toward social and emotional interactions. This enables them to better align with the child's developmental level and interests, which promotes development.

## 6. Existing Challenges and Barriers

The Dutch system for integrated early intervention and specialized youth care is fundamentally solid. However, its implementation faces complex systemic barriers that put its effectiveness under pressure. The transition to a decentralized model in 2015 aimed to organize care closer to the family, but in practice this has led to several bottlenecks, such as:

### Institutional fragmentation and bureaucratic ‘silos’

The most prominent challenge is the fragmentation of the legal and financial landscape. As mentioned before, care in the Netherlands is regulated by 4 separate laws:

- 1) the Youth Act (municipal);
- 2) the Social Support Act (Wmo, municipal);
- 3) the Long-term Care Act (Wlz, national/care offices); and
- 4) the Health Insurance Act (Zvw, private/insurers).

This “compartmentalization” or “siloining” between legislations creates a significant administrative burden for parents. In academic literature, this is often referred to as the “bureaucratic struggle” that parents must engage in to realize integrated care. The transition from the Youth Act to the Wlz is particularly experienced as difficult due to strict criteria and time-consuming procedures. This forces parents into the role of care coordinator, a task that often exceeds their capacity. The lack of seamless alignment between these domains hinders the realization of the principle “one family, one plan, one coordinator.”

### Capacity shortages and the impact of waiting lists

There is a growing gap between the complexity of care needs and the available capacity. This results in significant waiting times for both specialized diagnostics (youth mental health care) and placements in specialized day care (such as MKD and KDC). Given the neuroplasticity argument, these waiting lists in early childhood (0–6 years) are particularly harmful; delays in care lead to developmental delays that are more difficult and costly to correct at a later age. The causes of these waiting lists are multifactorial: on the one hand, there is an increase in the incidence of complex care needs; on the other hand, municipal budgetary frameworks are often insufficient to procure the required specialized care.

### Staff shortages and quality of care

Current shortages of trained professionals, such as special education specialists and pediatric physiotherapists, put pressure on the system. Staff shortages lead to high workloads, resulting in increased absenteeism and turnover. Systemically, this leads to a loss of knowledge and a decline in the quality of the therapeutic relationship with the child, which is essential for progress. In addition, staff shortages hinder innovation; when daily care can barely be guaranteed, there is no room for new, evidence-based methodologies.

### Socio-cultural accessibility and the equity gap

Finally, there is the challenge of accessibility for diverse socio-cultural groups. The Netherlands has a diverse population, but the care system is largely based on Western care concepts and assumes a high level of health literacy.

Families with a migration background often encounter language barriers and a lack of culturally sensitive care. There is a risk of ‘underdiagnosis’ or ‘overdiagnosis’ due to misinterpretation of behavioral signals. Moreover, taboos surrounding disabilities within certain communities can delay help-seeking. A proactive approach, such as deploying informal networks and peer contact in one’s own language, is important to bridge this ‘equity gap.’ Without specific attention to these barriers, the most vulnerable children remain out of sight of formal care structures, increasing inequality of opportunity in early childhood.

## 7. Future Priorities and Development Needs

In the Netherlands, we currently see a shift in focus from the medical-specialist model, in which the child is treated in a separate setting, to a socially inclusive model in which the child’s natural living environment is central. At the same time, many children still attend separate settings, and the threshold to mainstream childcare or education remains high. Day care centres (KDCs) are therefore still often used for children above the compulsory school age of 5, while transition to education remains limited for a large group of children.

A number of developments are:

### Inclusion and normalization

There is a strong movement toward more inclusive provisions, where children with disabilities are more often able to attend mainstream childcare or schools with ambulatory support, rather than specialized centres. At the same time, limited transition opportunities into education remain a significant challenge. In practice, especially in KDC admissions, professionals observe that the threshold for placement within (special) education appears to be rising, with increasingly strict

requirements regarding basic developmental or behavioural conditions for entry. As a result, day care centres (KDCs) continue to be used for many children above compulsory school age, while successful transitions into educational settings remain limited for a substantial group of children.

#### Focus on the ‘first 1000 days’.

From a policy perspective, there is growing attention for the national program ‘Kansrijke Start’, which focuses on the crucial first 1000 days of a child (from conception to the age of 2). The priority here lies in early prevention and identifying vulnerabilities at a stage where interventions have the greatest impact on brain development. By systematically investing in a healthy start and secure attachment, the aim is to prevent the need for more intensive and costly specialized care later in life. This requires closer collaboration between the medical sector (midwifery, maternity care) and the social domain (youth care).

#### Administrative simplification

Reducing the bureaucratic burden on families and the care system is becoming increasingly urgent. Due to the current fragmentation between legislative frameworks (Youth Act, Wlz, Zvw), very high administrative burdens arise for both parents and care organizations. Therefore, priority is given to achieving integrated coordination, so that parents no longer have to make connections between different service counters themselves. Initiatives such as the deployment of independent client supporters and the concept of “one family, one plan, one coordinator” aim to return control to parents and shift the coordination burden to care professionals. The neighbourhood team worker therefore has case management responsibility. This allows parents to focus again on their primary role: providing a stable and loving upbringing for their child.

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*Italy*

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HUMAN RESOURCE  
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## 1. Country Context and Policy Framework

Italy has a comprehensive national policy framework for early childhood support, grounded in the principles of universality, equality, and equity established by the National Health Service (Law 833/1978). Recent policy developments have strengthened the shift towards **integrated, person- and family-centred care**, particularly through Ministerial Decree 77/2022 and the National Recovery and Resilience Plan (PNRR), which promote continuity of care and stronger territorial services.

National strategies such as the *First 1000 Days Program* further reinforce a **preventive and early intervention approach**, focusing on reducing inequalities, promoting child development, and strengthening parenting capacities.

Service provision is regulated and delivered through a **multi-level governance system**, characterised by shared responsibility across sectors:

- **Health sector (National Health Service – SSN):** ensures universal access to early diagnosis, neonatal follow-up, and rehabilitation, with family counselling centres acting as key entry points for integrated and multidisciplinary care.
- **Social sector (municipalities and local authorities):** provides welfare measures and family support services, though activation pathways are often fragmented and not standardised nationwide.
- **Education sector (state, regions, municipalities):** delivers early childhood education and care (ECEC) services and inclusive schooling pathways, regulated at national and regional levels.

Despite a solid regulatory framework and advanced clinical practices, the Italian system faces persistent structural challenges, including fragmentation between health, social, and education services; significant regional disparities in access and quality of provision; limited continuity of care across developmental stages. These challenges highlight the need for **stronger intersectoral coordination, standardised care pathways, and reinforced family-centred approaches** to ensure equitable and effective early childhood support across the country.

## 2. Early Childhood Intervention Support: Access and Service Delivery

In Italy, early childhood intervention is embedded within a **universal health and welfare system**, but access pathways are characterised by both structured entry points and significant variability across regions.

### **Referrals and access pathways:**

Children can be referred to early intervention services through multiple channels, including:

- hospital services (e.g. neonatal intensive care units and discharge follow-up),
- family pediatricians,
- family counselling centres (consultori),
- educational services (nurseries and preschools),
- direct access initiated by families.

While this multi-entry system facilitates early identification, it also reflects a **lack of fully standardised referral pathways**, which can lead to fragmentation and delays in access.

### **Eligibility criteria:**

Eligibility is generally based on the presence of:

- **clinical risk factors** (e.g. prematurity, low birth weight, congenital conditions),
- **developmental delays or suspected neurodevelopmental disorders**,
- **social and environmental vulnerabilities** (e.g. poverty, parental fragility, limited access to services).

However, access to structured services and the intensity of support may vary depending on **regional resources and local service organisation**, resulting in unequal coverage.

**Accessibility of Services** are, in principle, **free or low-cost and universally accessible**, particularly within the National Health Service.

Nevertheless, access is often:

- **uneven across territories,**
- affected by **waiting lists and service availability,**
- dependent on families' ability to navigate the system.

This creates barriers, especially for socially vulnerable families, and highlights the need for more **proactive and coordinated outreach mechanisms.**

### **Qualified Personnel and service delivery model**

Early intervention services are delivered through **multidisciplinary teams**, typically including:

- pediatricians and child neuropsychiatrists,
- psychologists,
- speech and language therapists,
- neuropsychomotor and rehabilitation therapists,
- social workers and educators.

The service model is increasingly oriented toward **family-centred care**, aiming to involve parents as active partners and to address the needs of the entire family system.

However, continuity of care between services (e.g. hospital, community, education) remains a critical challenge.

### **Funding Mechanisms**

Funding is primarily ensured through:

- the **National Health Service (public funding)** for clinical and rehabilitation services,
- **municipal and regional resources** for social and educational services,
- additional support measures (e.g. allowances, welfare benefits).

Despite a solid public funding base, the system faces challenges related to:

- **resource allocation variability,**
- **limited integration of funding streams across sectors,**
- **and insufficient alignment between health, social, and educational investments**

### 3. Support for Family and Parents

In Italy, support for parents and families is formally recognised as a core component of early childhood intervention policies, with a growing emphasis on **family-centred care and parental empowerment**.

**Care coordination** is promoted within national policy frameworks, particularly through the shift toward **continuity of care and integrated territorial services**. In practice, coordination may involve:

- neonatal follow-up services,
- family pediatricians,
- counselling centres (consultori),
- local health and social services.

However, coordination is often **not systematically structured**, and families frequently play an active role in navigating and connecting services. Fragmentation between sectors (health, social, education) remains a key challenge, affecting the continuity and effectiveness of support.

#### **Parent training and counselling**

Parent support is delivered through a range of services, including:

- **family counselling centres**, which provide psychological support, parenting guidance, and support for parent–child relationships,

- early childhood programs (e.g. within the *First 1000 Days* framework), focusing on strengthening parenting skills and early relational competencies,
- clinical and rehabilitation services, where professionals often involve parents in intervention processes.

These services aim to enhance **parental competencies, awareness, and capacity to support child development**, although access and intensity vary across regions and local systems.

### Availability of peer-support groups

Peer-support opportunities are **not systematically embedded within the national service framework**, but are increasingly recognised as valuable for:

- reducing isolation,
- sharing experiences,
- strengthening parental confidence.

Such initiatives are often promoted by:

- third sector organisations,
- foundations and community-based services,
- local projects and pilot programs.

Despite their demonstrated value, peer-support groups remain **unevenly available and not structurally integrated into public service provision**, representing an area for further policy development.

### Key policy considerations

While Italy provides a solid foundation for parental support, key priorities include

- strengthening **structured care coordination mechanisms**,
- ensuring **equitable access to parent training and counselling services**,
- and **scaling up peer-support models** as an integral component of early intervention systems.

## 4. Transition to School-Age Services

In Italy, the transition from early childhood services (0–3) to school-age services (3–6 and beyond) represents a **critical phase in the care pathway**, requiring continuity between health, social, and educational systems.

Policy frameworks recognise the importance of this transition, particularly in relation to **inclusion, early identification of needs, and access to educational support measures**. However, implementation remains uneven across territories.

### Structure of the transition

After the age of three, children—especially those with developmental risks or disabilities—move from early intervention services into a more structured system involving:

- **child neuropsychiatry services**, responsible for diagnosis and therapeutic planning;
- **educational services and preschools**, which play a key role in observation and inclusion;
- **social services**, where activated, to support family needs.

Access to formal support in the school system is often dependent on **certification procedures**, which enable:

- the development of an Individualised Education Plan (IEP),
- the allocation of specialised support teachers,
- access to inclusive educational measures.

### Key strengths

- A **regulated and structured inclusion framework** within the education system
- The presence of **multidisciplinary assessment and intervention services**

- Increasing attention to **functional outcomes, participation, and inclusion** rather than only clinical aspects

### Critical issues and gaps

Despite these strengths, the transition phase is characterised by several systemic challenges:

- **Discontinuity between early intervention and school-based services**
- **Fragmented communication** between health services and schools
- **Delayed activation of support measures**, often reactive rather than preventive
- Strong dependence on **formal certification**, which may slow access to support
- High **territorial variability** in service availability and coordination

In addition, follow-up is not always systematically ensured beyond early childhood, despite evidence that **developmental difficulties may emerge or become more evident between 4 and 7 years of age**.

### Policy implications

This transition highlights the need to:

- strengthen **integrated, longitudinal care pathways (0–7 years)**,
- improve **coordination and information exchange between sectors**,
- promote **earlier and more proactive identification of needs within educational settings**,
- and reduce reliance on administrative procedures as the primary gateway to support.

Ensuring a smooth transition to school-age services is essential to prevent developmental risks from evolving into long-term educational and social disadvantage.

## 5. Effective Practices and Innovative Approaches

Italy has developed several **effective practices and innovative approaches** in early childhood intervention, particularly within the health sector, which provide a strong foundation for supporting children with developmental risks and their families .

### Effective practices

- **Structured neonatal follow-up programmes:** widely implemented across the country, these enable early identification of developmental difficulties and timely activation of targeted interventions, particularly for children at clinical risk (e.g. preterm infants).
- **Multidisciplinary care models:** services are delivered by integrated teams (health, psychological, and rehabilitation professionals), ensuring a comprehensive approach to child development and family needs.
- **Family counselling centres (consultori):** represent a key access point for prevention, psychological support, and parenting guidance, offering low-threshold and often free services.
- **Inclusive early childhood education services:** nurseries and preschools are designed to be accessible to all children, including those with disabilities, promoting early inclusion and participation.

### Innovative approaches

- A growing shift toward **family-centred care models**, which recognise parents as active partners in the intervention process and address the needs of the entire family system.
- Increasing policy focus on **prevention and early intervention**, particularly through frameworks such as the *First 1000 Days Program*, which emphasise early relational health, parental empowerment, and reduction of inequalities.

- Emerging efforts to move from a purely clinical perspective to a broader focus on **functioning, participation, and inclusion**, especially in the transition toward school-age services.

### Professional training and capacity building

- Italy benefits from a **highly qualified workforce**, particularly within the health sector, supported by specialised training in areas such as neonatal care, child neuropsychiatry, and rehabilitation.
- Multidisciplinary collaboration fosters **continuous professional learning and exchange of expertise** across different domains.
- Training opportunities increasingly integrate **relational and family-centred competencies**, although this is not yet uniformly embedded across all services.

### Key enabling factors

- A **universal public health system** ensuring broad access to services
- Established **clinical expertise and evidence-based practices**
- A **multidisciplinary and prevention-oriented approach**
- Progressive alignment with **family-centred and inclusive care principles**

## 6. Existing Challenges and Barriers

Despite a solid policy framework and the availability of services, early childhood intervention in Italy is still affected by **systemic gaps and barriers** that limit equitable access and effectiveness.

### Key gaps and barriers for families

- **Fragmentation of services:**  
Limited integration between health, social, and educational sectors results in discontinuous care pathways. Families are often required to coordinate services themselves, increasing the burden on caregivers.
- **Regional disparities and unequal access:**  
Availability, quality, and intensity of services vary significantly across regions and local areas, leading to **inequities in access and outcomes**.
- **Delayed identification and intervention:**  
Early signs of neurodevelopmental difficulties are often recognised only after 24–36 months, reducing the effectiveness of early intervention and increasing long-term risks .
- **Barriers related to social vulnerability:**  
Families experiencing poverty, social isolation, or limited access to information face greater difficulties in accessing services. Social risk factors are often **underestimated and insufficiently addressed**.
- **Administrative and procedural constraints:**  
Access to key supports (especially in the education system) often depends on formal certification processes, which can delay the activation of interventions.
- **Limited continuity of care (0–7 years):**  
Transitions between early childhood services and school-age systems are not always well coordinated, leading to gaps in monitoring and support.
- **Insufficient structured support for parents:**  
While services exist, structured care coordination, parent training, and peer-support opportunities are not consistently available across the system.

## 7. Future Priorities and Development Needs

Looking ahead, strengthening early childhood intervention systems in Italy requires a **system-level transformation** towards more integrated, equitable, and family-centred models of care.

### Key priorities for future development

- **Building integrated and continuous care pathways (0–7 years)**  
Develop structured, cross-sectoral pathways that ensure continuity between health, social, and educational services, with a longitudinal perspective on child development and family needs.
- **Strengthening care coordination and system navigation**  
Introduce formal coordination mechanisms (e.g. case management, care navigators) to reduce fragmentation and support families in accessing and navigating services effectively.
- **Ensuring equitable access across territories**  
Reduce regional disparities by defining minimum standards of service provision and investing in underserved areas to guarantee equal opportunities for all children and families.
- **Promoting early identification and preventive approaches**  
Scale up early screening, proactive outreach, and community-based interventions, particularly targeting children at social and developmental risk.
- **Embedding parental empowerment as a core pillar**  
Systematically integrate parent training, counselling, and peer-support into service provision, recognising families as active partners in care and key agents of child development.
- **Enhancing integration between health, education, and social systems**  
Improve communication, data sharing, and joint planning across sectors, especially during key transitions (e.g. entry into preschool and primary school).

- **Investing in workforce development**  
Strengthen interdisciplinary competencies, family-centred practices, and early detection skills across professionals in all sectors.
- **Simplifying access and reducing administrative barriers:**  
Enable earlier and more flexible access to support services, reducing reliance on formal certification as the main entry point.

### Strategic direction

Future development should move towards a model that is:

- **proactive rather than reactive,**
- **integrated rather than fragmented,**
- **family-centred rather than service-centred,**
- and **equity-driven**, ensuring that the most vulnerable children and families are reached early and effectively.

## CONCLUSIONS

The developed document has brought together detailed country profiles for Bulgaria, Romania, the Netherlands, and Italy, examining the legal frameworks, funding mechanisms, responsible institutions, and accessibility of health, social, and educational services for families of young children with disabilities. Each profile followed the same seven-part structure, providing a conceptual and empirical baseline that the M-POWER consortium set out to establish.

Across all four countries, policy is moving in the same strategic direction. Each national system is aligned with European priorities — in particular the European Child Guarantee and the related national action plans — and each is shifting, at least in principle, from a medical model centred on the child towards a holistic, family-centred approach that recognises parents as equal partners. Multidisciplinary teamwork, early identification, prevention, and a focus on the earliest and most critical years recur as shared reference points. This common aspiration is an important asset for the project, since it means the four partners are working towards a similar model.

Profiles also reveal real strengths to build on. The Netherlands stands out for the systematic monitoring of every child from birth to the age of four through youth health care, and Italy for its structured neonatal follow-up and highly qualified clinical workforce. Romania's recognition of early intervention in legislation in 2022 and its active partnerships between non-governmental organisations and universities, together with Bulgaria's growing body of family-centred and home-visiting practices, show that innovation is taking root in every setting — very often driven by non-governmental organisations, foundations, and academic institutions together with central systems.

At the same time, the review exposes a set of challenges that are strikingly similar across the four countries, despite their differing levels of resources and their distinct institutional arrangements:

- Fragmentation across sectors. Division between the health, social, and education systems is universal.
- Geographical and regional inequalities. Access is uneven everywhere, whether between urban and rural areas, across regions with differing provision, or for specific socio-cultural and migrant communities.
- Workforce shortages. A lack of qualified professionals, especially specialists trained to work with the 0–3 age group, generates long waiting times and delays the start of intervention.

- Late identification. Developmental difficulties are often detected too late, through a “wait and see” culture, the absence of standardized screening tools, or the recognition of needs only after 24–36 months of age.
- Weak transitions to school. The move from early intervention to school-age services remains poorly structured in every country, frequently depending on parental initiative or formal certification rather than on an automatic, coordinated handover between systems.
- Limited structured support for parents. Psychological and peer support for families is the least developed area across the board; peer support is widely valued but is not systematically embedded in any of the four national systems.

This final point is especially significant for the M-POWER Project. The consistent gap in structured, parent-to-parent peer support — found in countries at very different stages of development — confirms the relevance of the project’s central mission: to empower parents by building sustainable peer support mechanisms and strengthening their self-efficacy for independent living. The review demonstrates that this is not a marginal concern in any single country but a shared, systemic need, which reinforces the value of the transnational, mutual-learning approach on which the project is built.