Professionals

Cross-system practice for accessible communication, safety, autonomy, documentation, referral, and coordinated follow-through

Evidence-informed • person-centered • rights-respecting • implementation-focused

PRACTICE STANDARD

Do not confuse professional authority with complete knowledge. The person with the disability, their chosen supporters, and each discipline hold different pieces of the picture. High-quality practice connects those pieces and closes the loop.

1. Begin with direct, accessible communication

- Address the person directly, even when a caregiver, interpreter, or support worker is present.
- Ask how the person communicates best and what accommodations are needed.
- For covered entities, effective communication may require qualified interpreters, captions, accessible electronic text, large print, Braille, or other auxiliary aids/services depending on context.
- Allow processing time and avoid equating speech fluency, eye contact, reading level, or response speed with understanding.
- Create private communication opportunities when clinically, legally, and ethically appropriate.

2. Person-centered assessment

- Ask what matters to the person, not only what is wrong.
- Identify strengths, routines, communication methods, sensory needs, relationships, culture, trauma history when relevant, and successful supports.
- Distinguish baseline disability characteristics from new or acute changes.
- Assess environmental barriers and system failures, not only individual deficits.
- Document accommodations that worked so the next professional does not make the person start over.

3. Avoid diagnostic overshadowing

A new behavioral, functional, or communication change should not automatically be attributed to intellectual disability, autism, mental illness, or another known diagnosis. Consider pain, infection, medication effects, injury, sensory problems, sleep, trauma, abuse, environmental stress, and other causes appropriate to the professional role.

4. Recognize and respond to possible abuse or exploitation

- Know your profession's and jurisdiction's reporting obligations before a crisis occurs.
- Listen without blame and avoid repeated investigative questioning outside your role.
- Document the person's words or communication accurately and distinguish observation from interpretation.
- Address urgent medical and safety needs.
- Use accessible reporting and referral pathways.
- Consider retaliation risk, dependency on the alleged perpetrator, communication access, transportation, housing, and continuity of essential supports.
- Do not promise confidentiality you cannot legally or ethically provide.

5. Least-restrictive, autonomy-supporting practice

Safety and autonomy should be considered together. Before restricting a choice, identify the specific risk, whether the restriction is actually necessary, whether a less restrictive support could address it, who has legal authority, and how the person's preferences will be incorporated.

- Offer real choices rather than predetermined options presented as choice.
- Use supported decision-making strategies where appropriate.
- Time-limit restrictions and define review criteria.
- Document why a restriction is necessary and what would allow it to be reduced.
- Avoid organizational convenience as a substitute for individualized assessment.

6. Documentation that helps the next system

Document	Include
Communication	Preferred method, aids/services, processing needs, interpreter/ AAC details
Baseline	Usual functioning, behavior, communication, mobility, routines
Change	What changed, when, context, frequency, severity, witnesses
Person's voice	Preferences, concerns, goals, direct statements/communication
Risk & safety	Specific concern, immediate actions, retaliation/dependency issues
Actions	Referrals, reports, consultations, accommodations, education
Ownership	Who is responsible for the next step and by when
Closure	How follow-up will be confirmed and communicated

7. Warm handoffs and closed-loop referrals

A referral is not complete because a phone number was handed over. Joint-working research in intellectual-disability care identifies information-sharing and clarity of responsibility as important, while confusion about responsibility can undermine coordination.

- ☐ Explain why the referral is being made in accessible language.
- ☐ With appropriate permission/legal authority, transfer the information the receiving professional actually needs.
- ☐ Confirm the receiving service can meet communication and accessibility needs.
- ☐ Name the person responsible for the next step.
- ☐ Set a time for follow-up.
- ☐ Confirm whether the person successfully connected.
- ☐ Escalate when a high-risk referral fails rather than assuming another system handled it.

8. Cross-system case review: NOTICE → CONNECT → CLARIFY → ASSIGN → FOLLOW UP

NOTICE

Identify the signal: change, disclosure, missed care, injury, repeated crisis, exploitation concern, access barrier, or unmet need.

CONNECT

Look across settings and time. Is this an isolated event or part of a pattern?

CLARIFY

Clarify each discipline's role, authority, limits, and information needs.

ASSIGN

Give every action an owner and timeframe. 'The team will follow up' is not ownership.

FOLLOW UP

Verify completion, outcome, accessibility, and whether the person understood what happened next.

9. Discipline-specific prompts

Healthcare

What new medical cause must be ruled out? Is communication effective? Are consent and privacy supported?

Social work/case management

What environmental, relational, financial, housing, access, or system factors are affecting safety and participation?

Education

Are disability-related needs, accommodations, bullying/safety concerns, attendance changes, and family/student voice being connected?

Behavioral health

Could behavior communicate pain, trauma, coercion, sensory overload, or unmet access needs?

Law enforcement/justice

What communication accommodations, interview modifications, victim supports, or disability expertise are needed?

Disability services

Are service plans person-centered, least restrictive, monitored, and responsive to changes in risk or goals?

10. Team quality audit

- ☐ Was the person meaningfully included?
- ☐ Were communication accommodations actually provided?
- ☐ Did the team distinguish facts, interpretations, and unresolved questions?
- ☐ Were safety and autonomy both considered?
- ☐ Was a pattern across systems examined?
- ☐ Was each next step assigned to a named owner?
- ☐ Were deadlines documented?
- ☐ Was follow-up verified rather than assumed?
- ☐ Did the person receive an accessible explanation of the outcome?

References & trusted sources

Source hierarchy: current federal/public-health guidance and rights standards; systematic reviews and evidence syntheses; then supporting peer-reviewed studies. Legal requirements vary by setting and jurisdiction.

1. U.S. Department of Justice. ADA Requirements: Effective Communication. Source
2. Administration for Community Living. Person-Centered Planning. Source
3. Bobbette N, et al. Adults with IDD and interprofessional team-based primary health care: scoping review (2020). Source
4. Joint working between acute and disability services: mixed-method systematic review (2023). Source
5. WHO. Global report on health equity for persons with disabilities (2022). Source
6. Gorny F, et al. Collaborative teaching with people with intellectual disabilities: systematic review (2026). Source

EVIDENCE INTEGRITY

Where evidence is mixed, emerging, or primarily qualitative, this resource says so. Rights-based standards and legal requirements are not presented as randomized-trial findings, and associations are not presented as causation.

Prepared for Oklahoma Child Wellbeing • Disability, Safety & Autonomy

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