Intellectual Disability Psychiatry

A practical handbook

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Endorsed by the International Association for the Scientific Study of Intellectual Disabilities

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Foreword

People with intellectual disabilities are among the most complex and most rewarding of people to work with and the changes in attitudes, in services and in working practices that have occurred in this field in the UK and in some other parts of the world have been truly remarkable. Central to such changes has been the recognition of the importance of respect for the human rights of people with intellectual disabilities, as exemplified by the recent UN Convention on the Rights of Persons with Disabilities, together with an understanding that people with intellectual disabilities vary considerably in the nature and extent of their needs and in their strengths and vulnerabilities. The skills necessary to meet such needs are diverse and require collaborative work across disciplines and between staff from different agencies, including education, health, social services and different service providers.

Achieving much of what people with intellectual disabilities, their families, support workers and others working with people with intellectual disabilities might aspire to, in terms of social inclusion, choice and participation, will depend not just on the opportunities available to people with intellectual disabilities. Also central is ensuring, as far as is possible, sound physical and mental health, and the provision of support and communication strategies that are based on an understanding of individual need. This approach requires a clear understanding of the responsibilities of all those concerned with respect to the prevention, detection and treatment of ill health and ready access to primary and secondary health services and to specialist services as and when required. The extent of health inequalities and the attitudinal and practical barriers to primary, secondary and specialist health care services are increasingly acknowledged, if not, as yet, exactly resolved.

This book is a very welcome contribution to the literature with its specific focus on the mental health of people with intellectual disabilities. As exemplified by the different chapters, this has been an area of substantial development over the last few years. Clinicians and researchers have gained a much better recognition of the relevance of different conceptual models of understanding of the various developmental, biological, psychological and social factors that might predispose

to, precipitate and/or maintain the occurrence of particular behaviours and/or abnormal mental states affecting people with intellectual disabilities, and of the range of interventions that should be considered. The focus for the early chapters is on assessment and on the complex issues that can arise with respect to consent and the capacity of individuals to consent to interventions. The subsequent chapters address various aspects of psychiatric comorbidity and focus on specific issues that are becoming increasingly relevant, particularly with respect to people with mild intellectual disabilities, such as substance misuse and the needs of those arrested, charged with and/or convicted of offences. Other chapters focus on challenging behaviour and also on the mental health needs of older people with intellectual disabilities – perhaps best exemplified by the age-related needs of people with Down's syndrome. The final chapters are on interventions and on services.

This book brings together under one cover present-day knowledge and through its very publication makes a clear statement about the importance of these issues and of what can be done. This book is fundamentally optimistic in that its emphasis is on the benefits of sound assessment and informed intervention, yet it also brings to our attention the limitations of our knowledge and the complexity of the field.

Tony Holland
April 2009

1 Introduction

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Clinical involvement with, and awareness of, disability is a core component of the current undergraduate medical curriculum. It is one of eight key themes recommended by the General Medical Council which run through the entire five-year medical programme. Despite this, the majority of clinicians who only meet individuals with intellectual disabilities occasionally, often only have limited experience or training in how to work with this group where communication difficulties and variable symptom presentation create particular challenges in the consulting room.

Intellectual Disability Psychiatry: A Practical Handbook has been written and edited by working clinicians and academics in intellectual disabilities with the aim of creating a concise and practical text that addresses the clinical uncertainties that we face in everyday practice.

Working with people with intellectual disability is intellectually stimulating and professionally rewarding. All contributors have day-to-day clinical contact with people with intellectual disabilities, run diverse and innovative services and train undergraduate medical students and psychiatrists in training.

The complex clinical case work and emerging advances in epidemiological and health services research make this an exciting and interesting field. Recent government policy guidance provides an impetus for service innovation and the results of public enquiries help to prioritize initiatives to combat discrimination that people with intellectual disabilities can be subjected to when accessing health services.

People with intellectual disabilities experience high rates of mental disorders especially if problem behaviours are included in the prevalence rates. They are more likely to have associated physical health problems particularly people with more severe intellectual disabilities. There are many challenges in supporting people with intellectual disabilities overcome mental health problems. The ascertainment

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of mental disorders in this population is far from straightforward: the existing major classification systems, ICD-10 and DSM-IV-TR, are difficult to apply because the criteria for many mental disorders assume a level of ability and development that is lacking in our population. Furthermore, onset or relapse of a mental disorder may be unrecognized because of assumptions that people with intellectual disabilities behave in a certain way. Conditions that are treatable may therefore remain untreated and consequently the individual's needs are not met and their quality of life is reduced. *Intellectual Disability Psychiatry* will enable readers to effectively challenge this diagnostic overshadowing.

Chapters cover the key topics in the psychiatry of intellectual disability and include illustrative cases and examples of good practice. Communication is the topic of our first main chapter, and returned to many times in *Intellectual Disability Psychiatry* because it is so essential. Good communication skills can make all the difference for a clinician to be able to identify mental health problems in people with intellectual disabilities, and deliver treatment interventions.

In many parts of the world, there are no specific mental health services for people with intellectual disabilities. In other places, people with intellectual disabilities use a combination of specialist and mainstream services. We hope *Intellectual Disability Psychiatry*, written from a practice perspective, will help enable all psychiatrists to have the confidence and skills to work with people with intellectual disabilities. We have designed it to be an invaluable aid in achieving professional competencies and passing professional exams such as the MRCPsych. It is also highly relevant to other health professionals and social workers working with this client group.

We have deliberately avoided making *Intellectual Disability Psychiatry* an exhaustive research guide, though references to important papers are included as well as suggestions for further reading.

Psychiatry for people with intellectual disabilities is a very well established specialty in the United Kingdom, and several of our contributors use UK legislation and services to illustrate important principles. However, the content and information presented in *Intellectual Disability Psychiatry* can be adapted and applied in other settings outside the UK. We have intentionally adopted an international perspective in our community care chapter, and solicited contributions from three continents to help ensure an outward looking, forward thinking focus.

2 Effective Communication

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2.1 Introduction

This chapter aims to give some good practice points to facilitate communication with people with intellectual disability. In reality very few practitioners will have any training specific to the communication needs of this group of people. *Our Health, Our Care, Our Say: A New Direction For Community Services* [1] drew attention to the lack of skills and training; stating that there is a need to build up skills, especially in basic communication, in social care settings where only 25% of employees have a qualification. Healthcare for All [2] recommends that training for all health care professionals at undergraduate and postgraduate level must include intellectual disabilities on the curriculum.

People communicate in a variety of different ways and all have a right to communicate. A simple definition of communication is dependent upon three things:

1. a message to communicate
2. people who need to communicate with each other
3. a shared way of communicating.

This simple definition applies to everyone regardless of their age and ability to communicate.

Understanding and improving communication can greatly enhance clinical care and the experience of people with intellectual disabilities and those working with them. Moreover recent changes in UK legislation formalize a duty upon practitioners to strive to communicate effectively with individuals in order to maximize their understanding and ability to make decisions. For this reason we hope that this chapter

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will be used by the reader to help inform their understanding of many other parts of this textbook.

We discuss the different components of communication and the way that these impact upon the assessment and management of mental health disorders in people with intellectual disabilities. The basis of communication difficulties and their prevalence are outlined.

We also consider the general issues of communication in a clinical setting and the role of communication with others including carers, other disciplines and agencies that are frequently involved in the network working with a person with intellectual disabilities. The chapter is written from the joint perspective of psychiatry of intellectual disabilities and speech and language therapy and includes good practice points and case vignettes that can be used by readers to improve their own communication practices.

2.2 Background

There is a high incidence of communication difficulties in people with intellectual disabilities in comparison to the rest of the population. Research has indicated that anything between 50 and 90% of people with intellectual disabilities have such difficulties [3]. Therefore health professionals need to modify their communication to accommodate the communication needs of the person with intellectual disabilities. This will include spoken language, non-verbal communication such as facial expression, body language and gestures and any written forms of communication.

An approach that encompasses all the above and values all forms of communication equally is Total Communication. This is the communication approach that we have based the chapter on. The environment plays a key role in promoting effective communication. Considerations should also be made to ensure that communication is culturally appropriate with increased use of interpreters versus reliance on family members.

There is a higher incidence of sensory impairments with people with intellectual disabilities than in the general population. The literature shows that up to 60% of people with intellectual disabilities are likely to have a sensory impairment of some kind. 50% of people with intellectual disabilities were found to have a hearing impairment and between 30 and 70% have visual impairment [4, 5]. This figure can rise to 80% with certain 'at risk' groups, such as people with Down's syndrome.

There is also a higher incidence of physical disability amongst people with intellectual disabilities [2] and this can impact on communication skills. Such people are more likely to be dependent on others, therefore the ability and opportunity to communicate their needs and wishes and to have these acted upon is essential. The communication modes such as speech and signing may be more difficult for people with intellectual and physical disabilities to use easily.

From the speech and language therapist's perspective the communication skills of people with intellectual disabilities are described as:

1. **Pre-verbal:** This means that people do not have the cognitive abilities to understand words. They have profound and multiple learning disabilities. They can be helped to understand through routines, tone of voice, repetition, the context of the situation, objects and their own experience.
2. **Non-verbal:** This means that people have abilities to understand words but do not have the ability to express themselves using words and will use an alternative means, for example signing, pictures.
3. **Verbal:** People will have a variety of skills in understanding language and expressing themselves, predominantly using speech.

2.3 Professional obligations

Communication with patients, family members, carers and other professionals is an inherent part of everyday practice. There is a general assumption that both doctor and patient are able to understand what is being said and to contribute and respond in a way that is also understood. In clinical practice this assumption often does not hold true particularly in the context people with intellectual disabilities. In these situations doctors have a duty to communicate in a way that is appropriate for the individual.

This duty stems from the doctor's duty to preserve the autonomy of the patient, their right to self-determination and is a cornerstone of medical ethics. Increasingly this ethical principle has become incorporated into the law and has led to legal obligations set out in statute. See Box 2.1 for key statutes and policy applicable in England.

Box 2.1 Key statutes and policy in England

Human Rights Act 2000 [6]
Article 3: Freedom from torture or inhuman or degrading treatment
Article 14: Freedom from discrimination

Mental Capacity Act (MCA) 2005 [7]
Principle 2: 'A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.' (section 1(3))

Mental Capacity Act Code of Practice 2008 [8]
The MCA Code of Practice (chapter 3) provides general guidance for communication and further guidance specific to intellectual disabilities. It emphasizes

the importance of doing everything practical to help a person make a decision for themselves before concluding that they lack capacity to do so. It also states that to help someone make a decision for themselves, all possible and appropriate means of communication should be tried.

Mental Health Act 2007 [9]
Section 132B(1) imposes a duty to provide 'help in obtaining information about and understanding, . . . the provisions of this Act' . . . and other issues relevant to the Act.

Mental Health Act 1983 Code of Practice amended 2008 [10]
Chapter 2 outlines the duty to keep patients informed of their rights. Section 2.3 in the same chapter also outlines general guidance for communication with patients and states that everything possible should be done to overcome barriers to effective communication, which may be caused.

Section 2.4 highlights how communication difficulties affect each patient individually, so that practitioners can assess the needs of each patient and address them in the most appropriate way.

Chapter 34 specifically considers the needs of people with intellectual disabilities and people with autism and highlights the need to set aside sufficient time for preparation of suitable information and for preparation before meetings. Meetings should be held in an environment that is not intimidating, in order to allow the patient every chance to understand the information given.

Valuing People 2001 [11]
In paragraph 4.30 the white paper outlines the government expectation that organizations working with people with intellectual disabilities will develop communication policies and produce and disseminate information in accessible formats. For those with severe disabilities this may require individual communication techniques and effective use of new technology.

Good Medical Practice (2006) [12]
Published by the General Medical Council, this guidance for doctors imposes the duty on doctors to make sure, wherever practical, that arrangements are made to meet patients' language and communication needs.

Seeking Consent: Working with People with Learning Disabilities (2001) [13]
Published by the Department of Health specifically looks at the issue of consent in intellectual disabilities – both those individuals with and without the capacity to make decisions for themselves.

Beyond the duty to communicate is the therapeutic importance of good communication and its role in developing a therapeutic alliance between the doctor, patient and carers and other professionals around them [14].

2.4 Language skills of people with intellectual disability

Understanding of language

Many people with intellectual disabilities will have difficulties understanding what the health professional says. Some people will have developed good social language which masks their underlying difficulties, and it is important to be aware of this. Also some people will have developed an ability to understand simple abstract questions, for example, 'What did you do today?', 'Where's so and so?', but will find it harder to understand more complex abstract questions and concepts such as inference, for example, 'What would you do if ... ?', emotions and time concepts such as 'yesterday', 'tomorrow' and 'twice a day'.

It is useful to think about understanding from a simple developmental perspective while being mindful that the health professional is working with people who are adults and who will have had many life experiences which will increase their abilities. This means that sometimes people will be able to understand at a seemingly higher level because of something that they have experienced. In Box 2.2 we outline the key stages of communication development.

Box 2.2 Stages of communication development

1. Situational – people do not understand words but may understand because of the context, someone's tone of voice, experience and because of their routine.

2. Words are guides only to things that are present, that is people do what they usually do when they hear that word or see that sign.

3. Words are still guides only, but the things that are talked about don't need to be present – they could be in the next room.

4. Familiar words are recognized and understood and linked together in a typical way. Other parts of the sentence that they do not understand are ignored.

5. Sentences are understood using rules, for example, 'order of mention'. Misunderstandings can happen. For example, 'Before you have lunch you

need to ring your friend.' The person understands it as 'have lunch and then ring' but the friend is out when they ring.

6. Full understanding of every part of the sentence.

Often people with intellectual disabilities find it possible to understand what is being said, even though some words are not understood as they use a variety of different strategies. These include (i) their familiarity with the context or person speaking, (ii) guessing, (iii) understanding the speaker's non-verbal cues such as body language, facial expression and gestures or signing.

Box 2.3 Learning point

Think about what it is like when you are in a country where you understand only a little of the language. What helps you?

1. People talking slowly and giving you time to process what is being said.
2. People using everyday vocabulary, short sentences and simple grammar.
3. Non-verbal signals such as tone of voice, gesture or miming.
4. People using objects and pictures to explain.
5. The context of the situation, that is time of day, place.

Spoken language

People's ability to express themselves and the way in which they do it will vary. People may have difficulties in putting sentences together, a reduced vocabulary or unclear speech. This will mean that people with intellectual disabilities may have difficulties making themselves understood and the health professional may have difficulties understanding what the person is saying particularly if they do not know each other.

Due to neurological differences, some people with intellectual disabilities will have difficulties with pronunciation. People with physical disabilities such as cerebral palsy may have dysarthric speech. This means that the person has weakness in the

speech musculature and difficulties with breath support for talking. Their speech maybe characterized by imprecise articulation or mis-articulation. Other groups such as people with Down's syndrome may have articulation difficulties due to their anatomical differences such as high arched palate and low tongue muscle tone. Other causes of speech difficulties beyond the scope of this chapter include immature speech processes (phonology), dyspraxia and dysfluency.

Non-verbal communication

Non-verbal communication is very powerful and people gain much information from the non-verbal part of the message. Argyle and Alkema [15] found that verbal language provided 7% of the information whereas body language provided 55% and tone, pitch and intonation 38%. Types of non-verbal communication include body language, facial expression, gestures, signing, behaviour, tone, pitch and intonation. Arguably it is these methods of communication that are most difficult to interpret. During clinical practice they are largely dependent on the professional's familiarity with the person with whom they are working, which is often limited. An example where these non-verbal forms of communication have been used in conjunction with joint working with carers and support workers who know the client well is the Disability Distress Assessment Tool (DisDAT) [16] (Box 2.4).

Box 2.4 Good practice example – the Disability Distress Assessment Tool

A palliative care team working with people with intellectual disabilities developed the Disability Distress Assessment Tool (DisDAT). The tool enables clinicians to record the number and severity of distress behaviours and provides a check list to facilitate the process of identifying and treating possible causes of distress. Distress behaviours include vocalizations, speech, habits, posture and body observations including: pulse, respiratory rate, appetite and sleep. It was initially devised for people with intellectual disabilities requiring input from palliative care. It has been used in the assessment and management of other groups.

The health professional's non-verbal communication skills are particularly important when working with people with intellectual disabilities who do not always understand everything that is said. For example, if you are talking about something serious then your facial expression should be similarly serious otherwise there is a danger that the person will misinterpret what you are saying. The health professional's body language is a tool that can be used to enhance communication with

a person with intellectual disability. It can be used to be encouraging, for example, open body posture, sitting down at the person's level, particularly if they are in a wheelchair, to maintain appropriate eye contact.

The following case vignettes are used to illustrate common non-verbal communication in clinical practice.

Case vignette 2.1

A man called Fred who is non-verbal and can understand some single words but mostly understands through watching people and the context. He had been offered a drink with no sugar. The worker took sugar so she went and got it for herself. Fred saw this and held out his cup to indicate he wanted sugar too.

Fred is aware of the environment that he is in and notices the worker's behaviour. He uses a gesture to get sugar as a substitute for the words, 'Can I have some sugar'.

Case vignette 2.2

A woman called Sally who has some single words and short phrases was interacting with a worker who got up and put her coat on. Sally said, 'Bye' and pushed the worker to the door. Sally could not say, 'I'll show you out' so physically did so.

In this scenario Sally will have noticed the worker's body language as the worker stood up to leave; Sally used behaviour to substitute for the phrase 'I'll show you out'. This scenario also illustrates the potential for behaviours to be misinterpreted as challenging behaviour rather than a means of communication.

Box 2.5 Maximizing communication for people who are pre-verbal or who have limited understanding

1. Regular routines/timetables that people can anticipate.
2. Repetition of an activity so that people can start to predict what is going to happen and join in.
3. Tone of voice will help people to understand whether something is serious or funny.
4. Facial expression – make sure the expression matches what is being said.

5. Familiar situations and familiar rooms/buildings/places.

6. Sensory cues including sounds, smells and visuals cues.

7. Objects of reference – these are often real objects that symbolize something that regularly happens to help the person understand what is going to happen, for example, a person who goes swimming every week is shown their swimming trunks before they leave the house.

Use of language/social interaction

Some people with intellectual disabilities have more difficulties with using language in an appropriate manner, particularly people with autism. They may use learnt phrases or echo what is being said or echo something that they have heard from their past experience (delayed echolalia). In the clinical setting it is the responsibility of the health professional to ascertain how the person likes to be communicated with.

Written language

Although literacy skills are often reduced in this client group many people can understand written information if they have support, especially if it is written in an accessible way with pictures, symbols and photos. Using the 'Top Tips' in Box 2.6 will help make written information easier to read.

Box 2.6 Top tips for written information

1. Information should be relevant. Cut out anything that is not needed or is confusing.

2. Keep your sentences short. Use one clause per sentence. Try not to use conjunctions such as: but, therefore, because. Use 'and' only if you are writing a short list: eggs, milk and cheese. For longer lists, use bullet points.

3. Use plain English. Avoid jargon, technical language, abbreviations (apart from very common ones, e.g. TV, BBC) or difficult words. A long word can often be replaced with a short one, for example 'hard' not 'difficult', 'use' not 'utilize'.

4. Be consistent. Use the same words and phrases even if this seems repetitive. Use words and phrases that this client group will be familiar with.

5. If the person needs to do something, show this clearly. Use bold text or a bullet point.

6. Use numbers, for example '5', rather than words.

7. Lay the text out clearly, with plenty of white space.

8. Use Arial typeface and larger print – 16 point.

9. Do not use block capitals or italics or underlining as they are more difficult to read. Highlight important words in bold.

2.5 The impact of context on communication

Context refers to the physical environment or the emotional environment of the individuals. The physical environment can easily be manipulated in most circumstances. Ideally this would be quiet and comfortable. In the context of derilium, medical students are taught to interview the patient in a quiet brightly lit environment, thereby minimizing potential sources of distraction and opportunities for misinterpreting visual stimuli. The rationale for this approach is that the acutely confused patient has difficulty concentrating and maintaining selective attention. In specific disorders such as autism there is impairment of the attentional and perceptual abilities of the individual. This may present as an inability to focus on one thing or difficulty attending to additional extraneous stimuli such as the sound of advancing traffic when crossing the road. Many individuals including those with autism have sensory hypersensitivities (hyperacusis); these may be to touch, smell, sound and visual stimuli. This may cause distress to the individual and may be the origin of some challenging behaviours.

It is also important to consider the emotional environment for the individual. Emotional regulation can be challenging for many individuals. In states of emotional arousal such as anxiety secondary to pain or an unfamiliar environment, it can be difficult to participate in any exchange of communication in a meaningful way that enables the individual to both understand and remember what was said. In order to improve communication in these scenarios, individuals are usually able to regulate their own emotions. This requires the individual to be able recognize their internal state, to communicate that state and to be able to regulate their own response to it.

Studies show that strategies to regulate emotion are present from as early as infancy where rudimentary strategies such as looking away from aversive stimuli are used. For individuals with intellectual disabilities emotional self-regulation is largely dependent on the individual's cognitive abilities, social skills and previous experiences. It can be useful to adopt a developmental perspective when considering an individual's emotional environment and its likely impact on any interview or assessment.

Case vignette 2.3

David has moderate intellectual disability and autism; he is seen by the community psychiatrist in the health promotion room and spends the duration of the meeting rearranging leaflets. He is therefore not able to attend to the questions that he has been asked.

In this scenario David has difficulty maintaining selective attention; because he is anxious or because he has autism and because there are too many competing stimuli in the environment for him to attend to. As a result of this it is likely that David will not communicate as effectively as he is able to.

The detail of how to apply communication skills to the psychiatric consultation with people with intellectual disabilities is covered in Chapter 3. However Box 2.7 gives some essential pointers.

Box 2.7 What will help health professionals to understand?

1. Ask the person if they have any communication aids, for example, a communication passport which describes how they communicate
2. Make sure you are listening carefully.
3. Make sure you are looking at the person when they are talking.
4. If you cannot understand, try to make the person feel at ease by saying, 'Sometimes it is difficult for me to understand. Could you say it again, please.'
5. Don't pretend to understand when you have not.
6. Ask the person if it is OK to ask the carer/support worker for help with communication.
7. As you get to know the person you will find it easier to understand them.

2.6 Working with others

Working with others is a central feature of modern medical practice. The role of the collateral history in the assessment, examination and management of patients is an important skill in all medical disciplines. Increasingly doctors work within multidisciplinary and multi-agency teams which can facilitate the communication between different disciplines in the care of their client group. In the field of intellectual disabilities this should be no different. However in the context of more severe intellectual disabilities, the clinician becomes more reliant on the information provided by others.

The collateral history enables the clinician to gather a longitudinal history. Consulting with carers will provide in-depth knowledge including the person's likes/dislikes, distress signs and signals, allergies, work, social history and medical history. Further to this carers and others may be involved in monitoring the progress of the person and will therefore require information and understanding of the assessment/treatment in order to be able to support the patient to make use of any intervention and to maximize the efficacy of an assessment/treatment. The recognition of the carer's role has grown in importance as reflected by legislation. For example the Mental Capacity Act (MCA) 2005 in England and Wales requires the involvement of carers in the process of making best interest decisions for those who lack mental capacity. *Carers at the Heart of 21st-Century Families and Communities* [17] extends the rights of carers, and professionals' obligations towards them.

When consulted, carers have expressed their frustration with the way that professionals communicate with them [18]. Most frequently criticized is the information given to them, and repetition of questions asked by professionals. Various approaches have been implemented to reduce repetition and improve the effectiveness of information exchange and communication for patients, professionals and services. Here four approaches adopted in services in the UK – Health Action Plans, Person Centred Planning, the Single Assessment Process and the Care Programme Approach (CPA) – are described.

The Health Action Plan is a patient-held document that has been devised with the patient in a format that is accessible and meaningful for them and explains any actions needed to maintain and improve their health. It is described as a mechanism to link the individual and the range of services and supports they need, in order to get better health. Health Action Plans were introduced in England following the white paper *Valuing People* which proposed that all people with intellectual disabilities would have a Health Action Plan by the year 2005 [19].

Valuing People also proposed that Person Centred Planning should become a central process in intellectual disabilities services. It is an approach to ensure that services provide support in the way the person wants and puts them at the centre of the process. It helps people plan for the future and enables people to become more involved in their communities. Person Centred Planning encourages effective communication with individuals that enables individuals to express their needs,

preferences and ambitions in a way that is understandable to them and others in their network of professional support and friends. Services are developing individual approaches to Person Centred Planning. One approach is to use Person Centred Thinking tools [20] which include:

- what's working/what's not working
- what's important to the person and for the person
- hopes and dreams
- communication charts
- relationship circle

These tools, plus a variety of others, help an organization build up practices that encourage its employees to listen to the person and to find out what they want.

The Single Assessment Process aims to support person centred assessment and management of care for adults who have health and social care needs. It was introduced to the care of older people in 2001 following the national framework for care of older people and subsequently has been adopted by other services including community learning disability teams and forensic services. The Single Assessment Process comprises the following components:

- a single point of entry to the service
- a holistic assessment of needs including health, social care and carers' needs
- care planning
- delivery of care
- and subsequent review

The Single Assessment Process provides a framework that can coordinate the assessment of the health and social care needs of an individual and supports the communication and sharing of information between health and social care agencies.

The Care Programme Approach (CPA) is a co-ordinated approach to care planning that is provided for all individuals who have severe and enduring mental health needs. This is adapted for use in intellectual disabilities services for people with severe mental health needs in addition to their intellectual disabilities. Box 2.8 describes an example of this where a service improved the CPA process to make