Recommendations for caring for people with Borderline Intellectual Functioning

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I. Presentation

Borderline intellectual functioning (BIF) is a condition that affects a considerable proportion of the population, impacting on people’s quality of life and on their social and labour employment inclusion. Despite its social impact and frequency, BIF is still not sufficiently recognised by health, social, education, employment and legal systems at an international level.

Many years ago, an initiative was started in Catalonia by people working in the Government who created the Nabiu Catalan Association in order to ensure the maximum normalisation of this group in social and work contexts. As a result of this, a good model of employment inclusion for some people was achieved within the public administration.

Moreover, in 2009 the Ministry of Health supported a research project considered to be pioneering at an international level, and the Consensus Manual on Borderline Intellectual Functioning was drawn up, with the coordination of leading national and international experts such as Dr Luis Salvador Carulla, Dr Ramon Novell and Dr José Garcia Ibáñez.

The Catalan Government is well aware that caring for people with BIF requires a cross-cutting and inter-sectoral vision, involving health, education, social, employment and legal services. For this reason, a BIF Consensus Group was created in 2014, including professionals from different fields specialised in care provision for this group. The aim of the consensus group has been to draw up recommendations to improve the early detection and diagnosis of BIF, to define an individualised intervention plan, to improve social integration and to ensure interdepartmental and interdisciplinary coordination when caring for this group.

Today, Catalonia has a document providing recommendations for the comprehensive care of people with BIF which is pioneering at an international level. This has been made possible thanks to the collaboration of the experts in this field and the work they have carried out over the years for the Nabiu Catalan Association.
II. Introduction

Borderline Intellectual Functioning (BIF) is a condition that affects at least 3% of the population and that compromises to reach adequate levels of functioning (for example, a basic level of school education or access to the job market).

Studies exploring the international scientific evidence in this field are scarce and the results are highly variable. From the 12.3% of BIF population identified in the general British population (Hassiotis et al., 2008) to the 3% level identified in the Spanish population (Salvador-Carulla et al, 2011). In the context of the prison population, this prevalence is shown to be even more variable in the different studies available; from 5.7% (Murphy, Harnett & Holland, 1995), 11% (Herrington, 2009), 23.6% (Hayes, S.; Shackell, P.; Mottram, P.; Lancaster, 2007) and 32.1% (Porta, Martínez-Gómez & Pineda, 2003). The factors offered to explain these percentual variations are the use of different population samples, the lack of standardisation of the criteria used to categorise BIF, and the difficulty in identifying people with it.

Taking into account the situation, a group of experts drew up a declaration and framework document to provide a response to the challenges involved in caring for people with BIF. This document has come to be known as the Consensus Manual on Borderline Intellectual Functioning in which the group made 10 recommendations:

1. BIF is a meta-health condition that requires specific social, health, educational and legal attention. It is characterised by diverse cognitive dysfunctions which are associated with an intelligence quotient of between 71 and 85, and which result in deficits in the person both in terms of the restriction on the activities they can carry out and in terms of their social participation.

2. The childhood population with BIF is more vulnerable than the general population and therefore early detection is needed, as well as psychopathological assessment and an assessment of learning potential in these cases.

3. People with BIF need support to facilitate their school, employment and social adaptation and, in some cases, to also care for their specific health needs.

4. With regard to children and young people, it is expected that the concept of BIF will need to be defined with criteria that will help delimit a group of people who are unable to be schooled like most children of the same age and social environment, even though they do not have an intellectual disability.

5. The BIF concept presents a high level of variability and cultural baggage.
6. The difficulties facing the BIF population when accessing legal and administrative processes lead to a feeling of helplessness that must be addressed.

7. The early detection, assessment and care of people with BIF must be explicitly included in the health, social, school, employment and legal fields, in order to develop a society based on the principles of justice, equality and diversity.

8. More research must be promoted on the different aspects of BIF from health, social, educational, employment and legal perspectives.

9. Training on BIF should be improved for professionals in the different fields involved in providing care services for this group.

10. Specific spaces for interdepartmental coordination in different geographical areas should be promoted, as well as spaces for sharing knowledge between professionals from different sectors (health, education, work, social, and legal).

Based on these recommendations, the Catalan Government has set up a BIF Consensus Group, made up of professionals from the different fields, representatives of the different governmental departments involved, and by the Nabiu Catalan Association, in order to draw up a document providing recommendations on the comprehensive care of people with BIF.

**BIF and mental illness**

BIF is a heterogeneous group of syndromes, disorders or specific neurodevelopmental illnesses with potentially extreme variations in relation to normal functioning, which share one common characteristic: the secondary functional limitation of intellectual capacity.

In the latest diagnostic classifications (DSM-5 and CIM-10), BIF is still not classified as a clinical diagnostic category within the area of disabilities. It is classified, however, as a secondary category. Nevertheless, its coding is recommended in the diagnostic codes usually used in the health system (V62.89, according to CIM 9 and 10, and R41.83 according to DSM-5).

Considering the high level of mental illness in people with BIF, we feel compelled to highlight this dual condition.

A high degree of variability exists in the scientific literature when discussing mental illness in BIF. Having said that, research in this area is scarce and samples very rarely concentrate on this population in isolation; it being common to find studies in which BIF patients are selected alongside patients with minor or moderate levels of intellectual disability. In the past, the lack of bibliography on psychopathology in BIF has led to this demographic being compared with
patients with neurological disorders (Seidel, Chadwick & Rutter, 1975)

Usually, it is believed that at least 25% of subjects with BIF have psychiatric problems associated with cognitive deficits (Koller, 1983; Rutter, 1970; Gostasson, 1985).

Hassiotis (1999, 2008) carried out a study with a sample of 8,450 adults extracted from the ‘British National Survey of Psychiatry Morbidity’ database, in order to assess BIF prevalence in the population and the frequency of mental illness in this group. The sample studied shows 12.3% of people with BIF. Within this group, the prevalence of phobias, depression, neurotic disorders, personality disorders and substance abuse disorders (alcohol, cannabis and other drugs) was significantly higher than the group with normal levels of intelligence.

As people who are on the borderline between those with normal intelligence and those with intellectual disabilities, they will veer towards one side or the other of the border depending on the circumstances produced in their lives, their ability to overcome unfavourable situations, and the support they receive.

It is well known that some individuals with BIF function are completely independently, needing support only occasionally (Baxter et al., 2006), and functioning in a very similar way to the general population. However, there is a group of people with BIF, in the lowest part of this bracket, that overlaps with intellectual disability.

If the deviation occurs on the side of intellectual disability, the cognitive and functional deficits involved in managing daily life without appropriate support, the emotional repercussions of situations of failure, and the experience of feeling different from others, are aspects that can impact on their mental health and behaviour.

Furthermore, it should be noted that the lack of recognition and attention given from the standard mental health network to the inherent cognitive difficulties experienced—especially executive functions—and to the atypical way in which mental disorders are often manifested, as well as to the lack of training of professionals, can mean that their special needs are not identified and, consequently, that they do not receive the support needed to live as normal a life as possible.
III. Objectives and organisation

This document brings together the consensus on criteria related to actions, measures and support for the comprehensive care of people with BIF, targeted mainly at professionals in the health (general health and mental health), education, social, employment and legal spheres.

It also includes proposals and recommendations regarding organisational aspects, training, new programmes and other aspects that are considered important, and on which further work needs to be carried out to establish definitions, plans and implementation strategies.

This process, which covers everything from the detection of alarm signals and diagnosis to the elaboration of a personal intervention plan for people with BIF, including proposals to facilitate their employability, implies a joint effort by all professionals working in these fields.

The main objective of this document is to offer recommendations to:

1. **Improve early detection**, with the aim being to try to do this from early ages within the context of the education or health system, with professionals who are in direct contact with children, whether in general health contexts (paediatrics) or in specialist centres or preschool formal educational contexts (0-6 years). A second level of detection would be during primary and secondary education, since many students with BIF can also be part of the group of students at risk of school failure if they do not receive educational attention adapted to their needs.

2. **Confirm the BIF diagnosis**, being fully aware that at this moment in time it is not considered a diagnosis of mental health.

3. **Define an individualised intervention plan** at all life stages of the person with BIF:
   - Social and health monitoring.
   - Professionals and scope of intervention.
   - During childhood and youth: specific details in the Individualised support plans (IP) of students with BIF of the measures and additional or intensive support to be applied to

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1 If we look exclusively at the normal distribution of IQ, the population group with an IQ of between 71 and 85 would represent 13.6% of the total (EDAD 2008). The majority do not present any difficulties in their daily life. As indicated in the Manual, from a conservative perspective, the BIF Consensus Group has estimated that the population within this IQ range could be around 3% of the population. If we consider from this group those with a clear need for socio-health care, the 'baseline' would be around 1%. These would be people who have been subjected to demands that have exceeded their capacities from a very early age (due to ignorance within their environment of the problem) and have thus developed disorders as a result of this. Sometimes these disorders can be serious, as shown when people with BIF are admitted to HUSID and residential centres for people with intellectual disabilities or mental disorders. It is because of this that the early detection and recognition of their situation is important in the context of education.
help them achieve the objectives established at each stage of education.

- During adulthood: specific details in the Individualised support plans (IP) of adults with BIF of the measures and additional or intensive support to be applied to help them achieve (personal, social and labour) objectives in their lives, especially in relation to the difficulties they have regulating emotions and behaviour that can lead to mental disorders. Within the labour context, this group of people need to be considered as a particularly vulnerable group whose integration should be promoted.
- Support and potential aid for families.

4. **Ensure interdepartmental and interprofessional coordination** when providing care for people with BIF and also in highly complex situations, providing spaces for the coordination between the professionals involved in such cases.

**BIF Consensus Group**

In order to produce this document, the Government has set up the BIF Consensus Group, made up of professionals from the Catalan Government Administration who work in services related to the field, and external professionals who are experts in the subject. The BIF Consensus Group has been organised in the following way to facilitate full attainment of the objectives set.
The different agents involved in this system of the BIF Consensus Group are:

- The Catalan Government, acting as the driving force behind the project.
- Nabiu Catalan Association, responsible for promoting the need to develop this document.
- BIF Working Group, working system set up to elaborate this document.

**BIF Working Group**

The BIF Working Group is made up of the Advisory Board, the Coordination Group and the different working groups.

**Advisory Board**

The highest functional coordination board is responsible for approving the focus and scope of the project and the final document. It is made up of the following people:

From the Catalan Government:

- Joan Vidal de Ciurana. Cabinet Secretary. Ministry of the Presidency.
- Elsa Artadi. Director General for Interdepartmental Coordination. Ministry of the Presidency.
- Neus Jornet. Executive Secretary of the Catalan Board of Professional Training. Ministry of Education.
- Carme Altes. Head of Care Services for Diversity and Inclusion. Ministry of Education.
- Cristina Molina. Director of the Mental Health and Addictions Master Plan. Ministry of Health.
- Mònica Ribas. Assistant Director-General for the Care and Promotion of Personal Autonomy. Ministry of Labour, Social Affairs and Families.
- Maria Antònia López Sala. Head of the Programmes for Diversity Service. Ministry of Labour, Social Affairs and Families.
Professional experts:

- Dr Marina Romeo. Director of the Chair for the Labour Integration of People with Disabilities. University of Barcelona.
- Fernando Barbancho. Lecturer in Labour and Workplace Safety Law, University of Barcelona.
- Marcel·lí Medina. Labour insertion technical education teacher. Teaching Unit. HDA in Nou Barris.
- Dr Francisco Aguilera. Medical Director of Sanatori Villablanca. Institut Pere Mata.
- Dr Montse Pàmias. President of the Catalan Society for Child and Adolescent Psychiatry. Academy of Medical Sciences of Catalonia and the Balearic Islands.

Coordination Group

It coordinates project operations to facilitate the work done by the working groups.

It is made up of:

- Carme Altes. Head of Care Services for Diversity and Inclusion. Ministry of Education.
- Mònica Ribas. Assistant Director-General for the Care and Promotion of Personal Autonomy. Ministry of Labour, Social Affairs and Families.
In line with the objectives set, the following working groups have been set up: one group to develop objectives 1 and 2, two groups for objective 3 (one to draw up the Individualised intervention plan and another to work on labour integration aspects) and a final group for objective 4.

1. Working group for the Improvement and early detection and confirmation of the BIF diagnosis

Professionals responsible
- Carme Altes. Head of Care Services for Diversity and Inclusion. Ministry of Education.

Professionals
- Dr Claudina Vidal. Assistant Director of the Barcelona City and Hospitalet de Llobregat Division Institute of Legal Medicine and Forensic Sciences of Catalonia. Ministry of Justice.
- Mercedes Zayas. Psychologist at the Early Childhood Care and Development Centre (ECCDC), Passeig de Sant Joan. Ministry of Labour, Social Affairs and Families.
- Dr Montse Pàmias. President of the Catalan Society for Child and Adolescent Psychiatry. Academy of Medical Sciences of Catalonia and the Balearic Islands.
- Dr Montse Dolz. Advisor member of Master Plan of Mental Health and Addictions of the Generalitat of Catalonia and Director of the Child and adolescent Mental Health Department of the Paediatric Sant Joan de Deu Hospital in Barcelona"
2. Working group on the Individualised intervention plan

Entity responsible

Professionals
- Núria Roig. Technical education teacher, Care Services for Diversity and Inclusion. Ministry of Education.
- Mercedes Zayas. Psychologist at the Early Childhood Care and Development Centre (ECCDC), Passeig de Sant Joan. Ministry of Labour, Social Affairs and Families.
- Dr Montse Pàmias. President of the Catalan Society for Child Psychiatry.
- Francisco Aguilera. Medical director of Sanatori Villablanca. Institut Pere Mata.

3. Working Group on Employment Integration

Entity responsible

Professionals
- Glòria Gomez. Head of the Promotion of Diversity Section. Ministry of Labour, Social Affairs and Families.
- Marcel·lí Medina. Labour insertion technical education teacher. Teaching Unit. HDA in Nou Barris.
- Neus Palos. Labour Director Associació Catalana d’Integració i Desenvolupament Humà.
(ACIDH) (Catalan Association for Human Integration and Development).

- Dr Marina Romeo. Director of the Chair for the Labour Integration of People with Disabilities. University of Barcelona.
- Fernando Barbancho, Lecturer in Labour and Workplace Safety Law, University of Barcelona.

4. Working Group on Interdepartmental and Interprofessional Coordination

Entity responsible

- Mònica Ribas. Assistant Director-General for the Care and Promotion of Personal Autonomy. Ministry of Labour, Social Affairs and Families.

Professionals

- Ariadna Corbera Arumí. Technician in the Care Services for Diversity and Inclusion. Ministry of Education.
- Pere Bonet. President of the Advisory Board on Mental Health and Addictions. Ministry of Health.
- Montserrat Herrador Algaba. Director of the Care Centre for People with Disabilities in Paral·lel. Ministry of Labour, Social Affairs and Families.
IV. Improvement and early detection and confirmation of the BIF diagnosis
The indications provided in this chapter aim to summarise the information given in the Manual, specifying general guidelines aimed at professionals in the different systems of education, health, social, employment and legal spheres, who attend to people who are suspected of being or who show evidence of BIF in the areas of detection and diagnosis. The aim is to facilitate the coordinated action of these professionals, thus improving the care given to people with BIF. Furthermore, a specific section is included in the field of legal medicine and forensic science.

The document also includes a brief explanation of the resources involved in detection and diagnosis processes and a section with an explanation of the screening instruments that enable the identification of borderline intellectual functioning suspicions.

Process of detection and diagnosis

The following graph provides a schematic overview of the detection and diagnosis processes which are discussed in more detail in this chapter:
1. Detection process and alarm signals

Alarm signals are understood to be signs, symptoms or sets of manifestations which, if present at a certain age, should raise suspicions about BIF.

1.1. Children and young people

The detection of children with a high risk of BIF should be carried out as soon as possible so that interventions in education, health and social contexts can be adapted to their needs. To do this, it is vital that the professionals working with children and young people be aware of the alarm signals.

The detection of risk factors and alarm signals of BIF can be done on the basis of direct observation of the child's behaviour or on the basis of reports from the family or professionals in education, health or social spheres who are in contact with the child and/or the family.

Child development should be closely monitored routinely within the protocol of preventative activities and health promotion activities ('Healthy Child Programme') carried out in primary health care during the paediatric age, and in preschool educational contexts.

When there is any concern or suspicion that the child is not following normal levels of development, and given the presence of alarm signals, a specific assessment should be carried out to confirm the diagnosis.

The main alarm signals that professionals in the different centres working with children and young people should be aware of are described below.

1.1.1. Nurseries and schools

The observations carried out by preschool teachers and school teachers of children during learning activities, games and communication tasks are very useful in the case of BIF suspicions.

In these environments, alarm signals are:

- Low level of comprehension,
- Poor verbal expression,
- Difficulties in mathematical processes and reading and writing,
- Difficulties in the symbolisation process,
✓ Lack of attention and concentration,
✓ Low tolerance of frustration,
✓ Lack of initiative,
✓ Need to stick to rules,
✓ Low exploratory behaviour and lack of curiosity.

Detecting the presence of these alarm signals as soon as possible and specifying the characteristics present (intensity, triggers, inhibitors...) helps to provide relevant information to be passed on to specialised services.

When a teacher detects the presence of alarm signals, they must refer the case to the Early Childhood Care and Development Centres (ECCDC) in the case of preschool environments, and, in the case of schools, directly to the Psychopedagogical Assessment Team or Primary Healthcare professionals for them to confirm or rule out the suspicion of BIF through psychopedagogical assessments (PAT) or diagnosis (PHS).

1.1.2. Secondary Schools

The learning or relational difficulties mentioned in the previous section may sometimes go unnoticed or be only moderately evident in preschool and primary education. As a result, students who have BIF but have not been diagnosed continue to be expected to perform like other students at school, without receiving any additional support. Because of this, students with BIF end up failing at school, which can lead to disruptive behaviour or inhibitions, or can turn into behavioural disorders.

In Secondary Education, the alarm signals are:

✓ Information on learning difficulties on completing primary education,
✓ School failure,
✓ School failure associated with symptoms of depression and/or anxiety,
✓ School failure associated with behavioural disorders.

When a teacher detects the presence of alarm signals, they must refer the case to the Psychopedagogical Assessment Team or the Psychopedagogical Advisor at the school, or to Primary Healthcare professionals for them to confirm or rule out the suspicion of BIF through psychopedagogical assessments (PAT) or diagnosis (PHS).
1.1.3. Primary Healthcare Services (PHS)

Paediatricians, doctors, and nurses must identify risk factors and alarm signals during the routine check-ups of the ‘Healthy Child Programme’ within primary healthcare services, and they should also take into account any reports made by families in relation to the risk factors.

The following points should be taken into account during paediatric check-ups:

- Detection of changes in neurological development,
- Information relating to school performance,
- Behavioural changes, especially in the school sector,
- Factors concerning families.

1.1.4. Early Childhood Care and Development Centres (ECCDC)

From the early stages of life, ECCDC professionals must identify risk factors and alarm signals in children attending the centre who present difficulties in development.

When a child with alarm signals comes to the end of the care period in the ECCDC, and before being signed off of this particular service, a cognitive test should be carried out with a psychometric test to determine their IQ, with oral and manipulation tests, and also assessing their functioning in other areas (see section 5 of this chapter).

1.1.5. Psychopedagogical Assessment Teams (PAT) and Secondary School Advisers

Psychopedagogical Assessment Teams (PAT) and secondary school advisers must consider the alarm signals of BIF when they receive a request to assess a student from teachers based on the alarm signals described in sections 1.1.1. and 1.1.2.

In such cases, they should carry out the psychometric and functional assessment of the student with the instruments described in section 5 of this chapter.
1.1.6. Child and Adolescent Mental Health Centres (CYMHC)

When a CYMHC provides care services for a child or young person referred directly from a primary healthcare centre (PHS) or from a primary or secondary school or ECCDC, an assessment should be made of their intellectual capacity using the instruments described in section 5:

- Whenever there is a learning disorder,
- With any other psychopathology with a history of school failure or difficulty adapting to school.

In patients referred from ECCDCs with any kind of psychopathology and diagnosis indicating a probability of a borderline IQ, the assessment should be repeated at 8-9 years old.

1.2. Adults

During adulthood, people with borderline intellectual functioning have more difficulty resolving problems, whether at work or in personal relations, which often lead to constant failure at holding down a job or in their social and family relations, and to a greater presence of behavioural changes or mental illness.

They show difficulties in executive functions, i.e. in the skills needed to organise, plan and direct their behaviour towards their goals smoothly and efficiently.

They have problems:

- Behaving in a purposeful way,
- Resolving problems in a planned and strategic way,
- Paying attention to the different aspects of a problem at the same time,
- Problems paying attention in a flexible way,
- Suppressing spontaneous tendencies that lead to errors,
- Retaining the information needed to carry out an action in their working memory,
- Getting the gist in a complex situation.

Primary Healthcare Services, tertiary healthcare services or social services that detect any of the difficulties mentioned should refer the person to the Adult Mental Health Centre (AMHC) or the Specialized Service in Mental Health for People with Intellectual Disability (SSMHID).
2. Diagnostic process

This section describes the characteristics of the process of confirming the BIF diagnosis in each of the teams involved in assessing people who present alarm signals. The confirmation of the existence of BIF is carried out by the professionals on the following teams:

- ECCDCs for children already cared for by the ECCDC for other reasons, and for children referred from a preschool or primary healthcare centre (PHS).
- PAT for children and young people in primary and secondary schools. In secondary schools, the psychopedagogical advisor can also confirm the diagnosis.
- CYMHCs, for children and young people already treated in the CYMHC for other symptoms, or referred by primary healthcare centres (PHS) or from primary and secondary schools following a report from the PHS.
- AMHCs, in adults already treated in the AMHC for other symptoms, or adults referred from the primary healthcare service, from tertiary healthcare centres, or from social services.
- SSMHIDs, in adults already treated in the SSMHID for other symptoms, or adults referred from the primary healthcare service, from tertiary healthcare centres, from AMHCs or social services.

While an IQ of between 71 and 85 is sufficient to establish a diagnosis of BIF, this score does not provide us with a description of behaviour or executive functions (Artigas et al. 2007), which are essential to be able to adapt to the environment beyond the score obtained in the intelligence test. It is because of this that a more comprehensive study is needed to be able to describe and understand how these people process information and adjust their behaviour, as detailed in section 5, ‘Screening and identification’.

2.1. Child and adolescent population

2.1.1. Child development centres and early intervention (ECCDC)

A closed diagnosis is not provided in early childhood, with the emphasis being on the risk of BIF.

Preschool centres and Primary Healthcare Services (PHS) that detect alarm signals in a child must refer the case to the ECCDC for them to confirm or rule out the diagnosis of Risk of BIF.
The diagnostic process to be followed is as follows:

- Regarding the diagnosis:
  1. Pass psychometric and functional tests to assess the overall development of the child (see section 5 of this chapter).
  2. Draw up the report with the diagnostic impression of the risk of BIF (see section 5).

- Regarding therapeutic attention:
  1. Establish coordination with paediatricians, psychopedagogical assessment teams (PAT) and social services.
  2. Maintain constant coordination with families to inform them of the diagnosis and treatment guidelines.
  3. Before the end of the attention provided by the ECCDC commensurate with age, a cognitive assessment should be carried out, with a psychometric test to determine IQ, verbal and manipulative tests with the instruments explained in section 5 of this chapter, and a quantitative and qualitative analysis of the results obtained.
  4. If other behavioural or emotional difficulties are identified, the case should be referred to the CYMHC.

2.1.2. Secondary school educational psychology assessment and guidance (PAT) teams

During the psychopedagogical assessment of students at risk of BIF, the PAT professional or advisor of the secondary school should ensure that there are no other causes such as, for example, sensory alterations that justify the difficulties shown by the student, and must also make sure that the student has received school learning opportunities in line with their age.

The PAT or school advisor should check their IQ and any difficulties in adaptive behaviour, whether cognitive, social or practical, using the instruments included in section 5 of this chapter.

This assessment is carried out in a naturalistic context with contributions from teachers who know the student, other external professionals involved and the participation of the family.

If the PAT monitors a student diagnosed by the ECCDC as at risk of BIF, the team should confirm or rule out the existence of BIF during the psychopedagogical assessment carried out in the 3rd year of primary education.
In any event, the psychopedagogical assessment carried out by the PAT should guide schools in the measures and support needed to provide educational attention in a way which is adapted to the needs of students with BIF.

The diagnostic protocol to be followed by the PAT is as follows:

1. Conduct psychometric and functional tests to assess the overall development of the child or young person (see section 5 of this chapter).
2. Draw up the report on BIF, or the risk of BIF, in line with the results of the assessment.
3. Inform the family of the result of the assessment and of the proposed care plan.
4. Establish coordination with paediatricians, ECCDC, CYMHC and social services.

2.1.3. Child and youth mental health centres (CYMHC)

The care given to a child or young person referred to the CYMHC by the primary healthcare services (PHS) is as follows:

1. Application of the BIF diagnostic criteria, using the instruments included in section 5 of this chapter.
2. Before the end of the attention provided by the CYMHC in patients with BIF, another assessment should be carried out at the age of 18, with instruments standardised for use with adults, as detailed in section 5 of this chapter, as long as they have not been re-assessed in the last two years.

2.2. Adult population. Detection and diagnosis

In the access to care services in the adult population, we make a distinction between people already identified as having BIF, from the network of child and youth care services, and adults who have not been identified and are already treated by the mental health network (due to a mental illness and/or behavioural problems) or those who access the services for the first time.

- People with BIF who have already been identified and have been treated by the child and youth mental health network or the network specialised in intellectual disability (ID) and mental health:
1. Professionals of the child and youth mental health network should coordinate with professionals of the adult mental health network to ensure that the correct referral procedure is followed when referring from one network to the other.

2. If people are receiving attention in the network specialised in ID and mental health, they should continue to receive care in this network.

- People with non-identified BIF. Detection can take place in different services:
  1. Primary Healthcare Services,
  2. Specialised services in mental health,
  3. Social Services,
  4. Other services and third sector providers.

In both cases, it is important that the diagnosis and assessment is carried out by professionals, and that they be registered using diagnostic coding (CIE-9: V 62.89). This is a basic recommendation to help create a shared census among social and health service professionals.

2.2.1. Adult Mental Health Centres (AMHC and SSMHID)

In adult mental health centres, the same protocol is applied as with CYMHCs, in relation to the diagnostic criteria to be followed and the completion of the attention period (see section 2.1.3.)
3. Legal and forensic medicine

According to the Civil Code, the whole or partial modification of a person's legal capacity can only be implemented by means of a legal ruling. In order for this to occur, there needs to be evidence of a physical or mental illness or deficiency of a permanent nature that stops the person from being able to self-govern. In practice, this would mean that a whole series of medical and social documents would need to be submitted to prove the presence of a physical or mental deficit and the development of the person in society.

3.1. Detection

Within the protocol followed in family applications to modify a person's capacity to act, or in legal processes, a psychometric and functional assessment should be carried out.

The following points should be taken into account in this assessment:

1. Vulnerability:
   - Social and economic precariousness,
   - Disengagement from family or lack of significant family,
   - Inappropriate use of money,
   - Evidence or suspicion that the person is being manipulated by others or that they are making decisions for them (very important in cases of complex and elaborate crimes).

2. Assessment of different areas of the person's capacity:
   - Decisions that influence their health and their participation in research: Informed consent, consent/rejection of treatment.
   - Decisions related to assets:
     ✓ Important personal assets such as money or financial assets, sales, swaps, company shares.
     ✓ Personal assets of lesser importance such as small payments, regular payments of electricity and gas bills, or travel and holiday fees.

3. Other areas to take into account:
   - Autonomy in daily activities and travel,
   - Need for protection in everyday activities,
   - Capacity to enter into marriage.
4. Mental skills related to mental competence:
   - Skill or capacity to express a choice,
   - Capacity to understand information,
   - Capacity to assess the meaning of this information in relation to their own situation and the consequences of the different options,
   - Capacity to employ reason to understand the relevant information.

3.2. Diagnosis

To draw up a forensic medical report in penal and civil cases, the basic protocol is as follows:

1. Personal background:
   - Medical: to include a birth report, subsequent development and paediatric check-ups.
   - Reports from the ECCDC, CYMHC, AMHC or SSMHID.

2. School reports,

3. Social services reports: these are very helpful in assessing the patient's functionality,

4. The assessment should be completed with an interview with the family,

5. Interview or medical history of patient following the structure indicated below:
   - Biographical data,
   - Reason for the examination,
   - Personal somatic, psychiatric and toxicophilic background,
   - Family background,
   - The most relevant personal details are: the birth, psychomotor development, childhood/adolescence, school, further academic studies, work, affective relations and factors that may have contributed to or precipitated the appearance of mental illness.
   - It is most important to note: psychosocial learning; behaviour with others; skills in relations and acquisition of new friendships; motivation; personal autonomy skills: hygiene, order and cleanliness at a personal level and in their environment, meals, leisure.

6. Psychopathological exploration,

7. Psychometric explorations:
- Psychopathology: MMPI-II, SCL-90,
- Personality disorders: MCMI-III, MMPI-II, Minimult,
- Intelligence: RAVEN, TONI-2, WAIS - III.

8. Medical-legal considerations,

- Degree of personal autonomy,
- Ability to adapt,
- Ability to communicate,
- Functional repercussion,
- Responsibility.
4. Resources involved in detection and diagnosis processes

Different ordinary and specialised resources are involved in the detection and diagnosis processes described in this chapter, as shown in the graphic summary provided below:

**Ordinary resources**

Resources that are found in the ordinary environments of relations, learning and health regulations for children, adolescents, young people and adults. The work carried out by the professionals in these fields is essential in the process of detecting the first alarm signals of the existence of BIF.

- **Education:** nurseries, schools (preschool stage from P3-P5 and primary PE1-PE6), secondary schools and adult education institutes;
- **Health:** Primary Healthcare Services (PHS).
Support or specialised services

These are involved in the processes of detection, psychopedagogical assessment and diagnosis, and offer support and guidance for people with BIF and their families.

- **Education**: Psychopedagogical Assessment Teams (PAT) and secondary school advisers;
- **Work, Social affairs and Families**: Early Childhood Care and Development Centres (ECCDC);
- **Health**: Child and Youth Mental Health Centres (CYMHC), Adult Mental Health Centres (AMHC) and Specialised Service in Mental Health and Intellectual Disability (SSMHID);
- **Legal**: Institute of Legal Medicine and Forensic Sciences of Catalonia.

Other resources

Other resources related to detection and diagnoses are included in other chapters of the document. For example, the Catalan Employment Service (SOC), Care Centres for People with Disabilities (CCPD), and Labour Assessment and Orientation Teams (LAOT), see chapters VI and VII.
5. Screening and identification

Intellectual disability (ID) is an issue which has been debated intensely in relation to its denomination, conceptual definition, and the criteria used to classify it (Salvador Carulla & Bertelli, 2008). As a result, the BIF concept cannot be understood without detailed reference to the concept and classification of ID.

Thus, in the case of any suspicion of BIF, a numerical assessment of intelligence must be made, as well as an assessment of the functionality of the person at risk of BIF.

5.1. Screening and identification phase

The screening and identification phase must incorporate a comprehensive and multidisciplinary system that uses the same instruments to identify suspicions of Intellectual Functioning and Adaptive Functioning below the population mean in a sensitive way, especially for people at risk for BIF or who may present complex and concurrent social and health needs.

While acknowledging the operational and functional value of the different diagnostic instruments available, one single instrument has been selected to assess each of the dimensions shown in the table below. Some of the instruments selected—which are presented briefly below—are also cited in the Manual and others are used extensively among professionals in the different fields.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Instrument</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive screening assessment</td>
<td>K-BIT</td>
</tr>
<tr>
<td>Complete cognitive assessment</td>
<td>WISC-V (children) WAIS-IV (adults)</td>
</tr>
<tr>
<td>Functional Assessment and Adaptive Behaviour</td>
<td>ICAP</td>
</tr>
<tr>
<td>Mental Health and Behavioural Assessment</td>
<td>HoNOSCA (children) – HoNOS-DI (adults)</td>
</tr>
</tbody>
</table>
5.1.1. Cognitive Assessment (Intellectual Coefficient)

The prior use of the instrument known as K-BIT is proposed as a ‘screening’ tool in new cases in which there has been no previous intervention from the mental health network: it is quicker to process, and if the result is positive and a possible case of BIF is detected the next step would be WISC-V (children) or WAIS-IV (adults).

K-BIT Brief intelligence test by Kaufmann

The K-BIT is designed to measure the general intelligence of a wide age-range of individuals (from 4 to 90 years old).

It is quick and easy to apply (between approximately 15 and 30 minutes), making it an excellent tool to carry out the ‘screening’ required to make a quick assessment of general intelligence and also to provide data to help decide whether a more in-depth evaluation is needed.

It is made up of two subtests:

- Vocabulary: Measures the verbal ability needed to give oral responses. Assesses verbal skills, language development, the formation of verbal concepts and the flow of information.
- Matrices. Measures non-verbal skills and the capacity to resolve new problems. Assesses the capacity to resolve reasoning problems through visual, figurative and abstract stimuli.

The application of the K-BIT provides the professional with a verbal intellectual coefficient (IQ), a non-verbal IQ, and a compost IQ that sums up the person’s overall performance in the test.

Furthermore, none of the tests require a motor response, meaning that it can also be applied to people with any kind of physical impairment.

The regulations for interpreting the K-BIT are straightforward. The test itself has a simple system for interpreting the scores obtained in each subtest.
**WISC-V scale**

The Wechsler Intelligence Scale for Children (WISC) is a scale for assessing intelligence and intellectual aptitude in children in clinical and psychopedagogical environments. Developed on the basis of the Wechsler-Bellevue scale, it was designed by David Wechsler to be applied to people under 16. It comprises two subscales—verbal and manipulative—each of which contain six subtests. As with the WAIS, it provides us with an overall score called the Total Intelligence Quotient.

**WAIS-IV scale**

WAIS is a test designed to assess overall intelligence, understood as an IQ concept, in individuals between 16 and 64 years old, of any race, intellectual level, education, socio-economic and cultural level and reading level.

It is individual and contains two scales: verbal and execution. It is based on Spearman's bifactorial theory of intelligence, taken from a global perspective, since it comprises skills which are qualitatively different (traits), but not independent. However, the sum of these skills is not only expressed in relation to their quality, but also in relation to non-intellectual factors such as motivation. Intelligence involves a certain degree of overall competence.

**BIF criteria results**

K-BIT, WISC-V and WAIS-IV scale: Intellectual coefficient between 71 and 85.

**5.1.2. Assessment of Adaptive Functioning**

The BIF concept associates different cognitive dysfunctions with an intellectual coefficient of between 71 and 85, which result in deficits in the person's functioning both in terms of the restriction this implies on the activities they can carry out, as well as in terms of their social participation. It should be noted, therefore, that cognitive deficit is not solely restricted to a simple question of IQ, which is why it is necessary to carry out an accurate assessment of the person's adaptive functioning.
ICAP Inventory for Planning Individual Services and Programming

This is a tool which, among other things, enables standardised assessments to be carried out of adaptive behaviour and behavioural problems.

In essence, the ICAP comprises a systematic register of relevant data on the person receiving attention by a particular service and two regulated measurement instruments: one on adaptive behaviour and another on behavioural problems. The ICAP is applicable to people of all ages and is basically designed to be used for people with disabilities, although it can be used with other population groups who are sometimes excluded from the previous category; for example minors with marginalisation problems, the elderly, people with mental health problems, people with Borderline Intellectual Functioning, etc.

The ICAP consists of:

- A register of the diagnosis or diagnoses of the person, personal details, functional limitations (mobility, vision, hearing and general state of health).
- An adaptive behaviour test that measures the person's level in relation to the basic skills needed to live independently in their environment which is structured according to four scales:
  1. Social and communication skills (both expressive and receptive language).
  2. Personal Life skills (independence in relation to the most immediate personal needs such as eating and dressing).
  3. Community Life skills (for example, the autonomous use of public transport, the person's ability to use money or a watch).
  4. Motor skills (fine and gross).

Standardised scores are provided for each scale, as well as a general one which encompasses all the others: age, percentiles and typical scores, among others. In addition, it is also possible to establish a Profile of Instructional Implications in which two ages are obtained, from which the content of the specific programmes targeted at the people assessed can be adapted, in such a way that the level of difficulty is not perceived as either too easy or too difficult by the person.

A behavioural problem test, which analyses a person according to eight areas, from which four standardised indexes of behavioural problems are extracted. Internal, Antisocial, External and General.

The ICAP is a relatively simple and quick test (20 minutes when the professional is familiar
with it) that can be completed independently (self-administered) by someone who knows the person being assessed. Any professional with the most basic experience in completing questionnaires can fill in the ICAP (teachers, monitors, social workers, psychologists, etc.). The interpretation of the ICAP and the decisions taken subsequently about the person assessed should be made by qualified professionals.

A version has been adapted to and validated for the Spanish population. (Montero, 1996).

**BIF criteria results**

Level of Service score of the ICAP scale 7 - 8: Limited attention to the person and/or periodic monitoring.

**5.1.3. Assessment of Mental and Behavioural Health as well as the person's needs**

**“HoNOSCA” scale**

The HoNOSCA scale (The Health of the Nation Outcome Scales for Children and Adolescents) is an outcomes measure designed to be used in mental health services treating children and adolescents below the age of 18. It is focused on general health and social functioning.

It includes 15 items that measure behaviour, deterioration, symptoms and social functioning. The items are classified on a scale of 0-4 and the results or changes in scores can be attributed to the services received. The score is obtained using a glossary with detailed descriptors of the level of seriousness and complexity. Information from all available sources should be taken into account when filling in the qualifications, including the user of the service and their family.

**“HoNOS-DI” scale**

The Health of the Nation Outcome Scales for People with Learning Disabilities (HoNOS-LD – Roy, A.; Matthews, H.; Clifford, P.; Fowler, V.; Martin, D. M., 2002), is an instrument comprising a set of scales designed for people with intellectual disabilities and mental health problems. It was designed to obtain an overall index of functioning.
It was developed on the basis of another instrument: Health of Nation Outcome Scales (HoNOS – Wing, J.K.; Curtis, R. H., Park, S.B.G.; Hadden, S.; Burns, A., 1998). This was developed by the Research Unit of the Royal College within the framework of the Health of the Nation project of the British Department of Health. It comprises scales designed to measure different physical, personal and social problems associated with mental illness. The instrument was designed by the government administration by Mental Health professionals, to be used routinely in a clinical context.

The HoNOS-DI is a brief scale comprising 18 items, which assesses the problems frequently presented by people with intellectual disabilities in different spheres. It is made up of four key areas: behaviour, cognition, clinical problems and daily life activities. Specifically, it includes behavioural problems (auto- and hetero-aggression, impulse control), problems associated with cognitive deficits (attention, concentration, memory, orientation and communication), affective problems, hallucinations and delirium, health problems, problems related to autonomy and problems in the social sphere. The highest score possible is 72. The higher the score, the more serious the case.


5.2. Criteria for differential diagnosis

Finally, apart from screening, in the case of non-identified adults, criteria for differential diagnosis should be considered. The idea of such criteria is to avoid cases in which IQ may conceal cases that are not BIF, but which present similar levels of IQ. Such criteria would be:

- That there is no history of chronic mental illness without cognitive deficit.
- History of chronic use of psychiatric medication
- Age range: in order to rule out the possibility of secondary cognitive deterioration, evidence must be provided that the cognitive deficit started before 18 years of age.
- That there is no history of previous cranial trauma, secondary brain damage as a result of an incident or a process of early dementia.
### 5.3. Diagnostic assessment instruments

<table>
<thead>
<tr>
<th>Instruments</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Verbal and non-verbal intelligence tests</strong></td>
<td></td>
</tr>
<tr>
<td>BSID. Bayley scale of infant development</td>
<td>0 - 2.5</td>
</tr>
<tr>
<td>MSCA. McCarthy's Aptitudes and Psychomotricity Scale for children</td>
<td>2.5 – 8.5</td>
</tr>
<tr>
<td>WISC-V. Wechsler's Intelligence Scale for children</td>
<td>6 – 16.9</td>
</tr>
<tr>
<td>WIPPSI. Intelligence scale for preschool and primary education</td>
<td>4 – 6.5</td>
</tr>
<tr>
<td>K-ABC. Kaufman's assessment battery for children</td>
<td>2.5 - 12.5</td>
</tr>
<tr>
<td>K-BIT Brief intelligence test by Kaufmann</td>
<td>4 - 90</td>
</tr>
<tr>
<td><strong>Non-verbal intelligence tests</strong></td>
<td></td>
</tr>
<tr>
<td>Raven's Progressive Matrices Test</td>
<td>12 - 65</td>
</tr>
<tr>
<td>TONI-2. Non-verbal intelligence test</td>
<td>5 – 85.9</td>
</tr>
<tr>
<td>Leiter – R</td>
<td>2 – 20.9</td>
</tr>
<tr>
<td><strong>Adaptive Functioning Assessment</strong></td>
<td></td>
</tr>
<tr>
<td>Inventory of adaptive skills (CALS), curriculum of adaptive skills (ALSC), and inventory to plan individual services and programmes (ICAP).</td>
<td></td>
</tr>
</tbody>
</table>
V. Individualised intervention plan
1. Children and adolescents diagnosed with BIF or as being at risk for BIF

Care for people with BIF should be individualised and focused on their needs, with a comprehensive and holistic perspective that takes into account health, social and educational aspects. For this reason, people with BIF and their families are provided with an Individualised intervention plan with an interdisciplinary approach that guarantees that a single key worker is assigned to the case to ensure personalised monitoring and the coordination of the different services involved in looking after the case.

People with BIF have educational, social and employment difficulties similar to those of people with intellectual disabilities (ID), but to a lesser degree. This section refers to the care given to children and adolescents who have been diagnosed with BIF or at risk for BIF.

At each stage of development, the different resources provided by the Government of Catalonia involved in attending to people with BIF in the educational, social and health fields are listed.

1.1. Children between 3 and 6

Therapeutic plan

The ECCDC establishes a therapeutic plan for the child at risk of BIF which must be interdisciplinary.

1. At a clinical level, intervention in the different areas of development:

- Cognition,
- Attention and memory,
- Communication,
- Language,
- Symbolisation,
- Emotional affective area,
- Fine and gross motor skills.
2. In work with families or guardians:

- Periodic interviews with parents (provide parenting guidelines, family habits, suitable games for the child's age and stage of development...);
- Include the family in the sessions;
- Share the working objectives with the family;
- Promote relational strategies with parents;
- Recommend other community resources to the family.

**Action in the educational field**

At school, which is the most natural space in which the child develops, the steps to be followed are as follows:

1. In addition to the universal measures implemented in the classroom, the school, with the guidance of the PAT, should assess the merits of providing the child with any kind of additional or intensive support.

2. The teaching staff should agree on the educational care measures to be taken, depending on the level of functioning and learning of the pupil, and carry out appropriate monitoring (class teacher, special education teachers, Attention to Diversity Team...) of their development.

3. In school meetings with the family, the teaching staff and the family should agree on specific and shared guidelines to follow and should monitor the progress and success of these agreements.

4. The Attention to Diversity Team of the school, or the equivalent body, should be informed of any support that the pupil is receiving.

5. On completion of preschool education, all information about the actions carried out and of any support received by the student should be passed on to the primary school teacher. It is recommended that these be registered in writing in the end of preschool report.

**Coordination between the different resources involved**

**Coordination between ECCDC and the Education authorities**

1. Inform the PAT of children at risk of BIF.
• At the time the risk is diagnosed if the child is already at school;
• When starting school;
• When starting to receive attention from the ECCDC.

2. Share clinical information about the child and the family to be able to work effectively together. (Coordination meetings should take place every six months.)

3. Clinical report explaining the BIF diagnosis to the parents (including a cognitive and functional development assessment) with degree of parents' awareness and acceptance of the diagnostic guidelines.

Coordination between ECCDC and CYMHC

1. In cases of risk of BIF and behavioural changes and/or associated emotional changes, the case should be referred to the CYMHC.

2. The end of care report from the ECCDC must include the day and time of the first visit to the local CYMHC.

Coordination between ECCDC and Social Services.

If the patient at risk of BIF is considered to be at social risk or not receiving due attention from their family, the ECCDC worker must inform social services.

Coordination between ECCDC and the Primary Health Service Paediatric Team.

1. On arriving at the ECCDC, the paediatrician should be informed of the start of care services and the diagnostic impression.

2. When care services are ended, the paediatrician should be notified in the same way.

1.2. Children and young people over 6.

The treatment plan

A therapeutic plan is established by the CYMHC
1. The CYMHC intervenes when the child/adolescent presents a mental illness or behavioural changes. In such cases, the specific intervention needed in accordance with the disorder presented should be carried out, with aspects related to BIF also being covered.

2. The intervention should include different levels:
   - Behavioural: specific work on personal autonomy.
   - Emotional: work on self-esteem, both in terms of limitation and capacities.
   - Social: prevention of bullying at school, sexual abuse, drug consumption and other addictive behaviour. Marginal groups.

3. In work with families:
   - Psychoeducation on BIF: strategies for managing behaviour and emotions, strategies for increasing functionality.
   - Recommendations for avoiding risk of abuse.
   - Support and strategies to facilitate structured and supervised contexts for the child at risk of BIF.

4. In children that have been referred for a first visit from the ECCDC, the CYMHC must aim to establish links with the resource. If the family fail to attend the visit, contact must be established with the family by telephone. If no adequate response is provided, local social services must be informed.

**Action in the educational field**

Children between 6 and 12 years old - Primary Education

During primary education, the steps to follow are the same as in preschool education, except that:

1. The need for additional or intensive measures and support may become more apparent and it may become necessary to specify them in an Individualised support plan (IP).

2. In the event that the PAT monitors a child diagnosed at risk of BIF by the ECCDC, during the third year of primary education the risk indicators detected should be reassessed (with a psychometric and functional assessment carried out by the PAT if significant learning difficulties are present; or by the CYMHC if the problems are more general).
3. In the child already diagnosed with BIF, but who is not being monitored by the health services, if behavioural or emotional difficulties are observed during the PAT psychopedagogical assessment, the child should be referred to the local CYMHC.

4. If a child presents indications of social risk, the Social Commission of the school or an equivalent body should monitor the case.

5. In the change from primary to secondary, the school should pass on information about BIF students; notifying them if an IP is in place, or if monitoring has been carried out by the PAT. The transfer should highlight the actions that have helped the pupil have good learning experiences, in order to facilitate the continuity in secondary education. This transition must be carried out providing support for the family through meetings with the school and with the PAT if necessary.

Older children and adolescents over 12 - Compulsory Secondary Education

1. On the basis of the information provided by the primary school, the secondary school will decide on the best educational attention for the pupil:
   - Elaboration of an Individualised plan (IP) specifying the additional and intensive measures and support mechanisms applied.
   - Referral to PAT: If the PAT or school advisor monitors a child at risk of BIF who is not receiving care from the CYMHC, the risk indicators detected should be reassessed on completion of secondary school (carrying out a psychometric and functional assessment).
   - Development monitoring during secondary school.

2. If the child already diagnosed with BIF shows behavioural or emotional difficulties during the PAT psychopedagogical assessment, the child should be referred to the local CYMHC.

3. If a child presents indications of social risk, the Social Commission of the school or an equivalent body should monitor the case.

4. Share agreements and monitoring with the family, as well as the actions carried out at school and home in meetings held as frequently as is deemed necessary.

5. Inform the Commission for the attention to diversity of the child's school, specifying the support the child is receiving.

6. The school will draw up a document of guidelines for the pupil in collaboration with the
school advisor or the PAT if necessary, to ensure educational continuity and labour orientation, taking into account the characteristics of the child with BIF: This document must contain the most relevant aspects of the competency-based learning of the student throughout their education.

7. If the child is receiving attention from another service external to the school (CYMHC, Social Services...), the contributions made by these services will be taken into account in the document.

8. The class teacher, school advisor and/or PAT, if necessary, will set up a meeting with the family and the student to help in this transition.

Coordination between the different resources involved

The following coordination task will be carried out during the intervention:

Coordination between ECCDC and the Education authorities

Periodic coordination meetings for patients receiving care from the ECCDC should include information related to BIF in patients with comorbidity:

- Intervention carried out by the ECCDC and development.
- Work with the family.

Coordination between ECCDC and Social Services.

Social Services: in cases where a social risk is detected, social services should be contacted in order to monitor development. In such cases, referral to the Care Centre for People with Disabilities should be considered, to assess if a disability certificate would be appropriate.

Coordination between ECCDC and the Primary Health Service Paediatric Team.

Primary health service paediatric team: the paediatrician should be informed about any interventions carried out with the patient during inter-consultation meetings.
2. Adults with BIF and mental illness

As mentioned above, approximately 25% of people with BIF have psychiatric problems related to cognitive deficits; with these being the main reason for them being in contact with the Mental Health Network.

2.1. Intervention process

Care needs to be taken to ensure that adults with BIF who present mental illness and/or behavioural problems receive support from the Mental Health Network (MHN), whether on a general or specialised basis.

While there are many doubts about the benefits of using specialised services for intellectual disability with people with BIF—since they can perceive this as a form of stigma—the experience in Catalonia, after years of operation of the Specialised Network in Intellectual Disability (ID), indicates that nearly 25% percent of people in this group may benefit from the resources, services and support offered from this network (SSMHID and HUSID), (see Quaderns de Salut, No. 5, Ministry of Health, Government of Catalonia, 2003).

<table>
<thead>
<tr>
<th>Territorial Area of Catalonia</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults ≥18 years old</td>
<td>5,979,952*</td>
</tr>
<tr>
<td>People with BIF (3% of adults)</td>
<td>179,398</td>
</tr>
<tr>
<td>People with BIF + Mental Illness (25% of people with BIF)</td>
<td>44,850</td>
</tr>
<tr>
<td>BIF population potential general MHN (75%)</td>
<td>33,637</td>
</tr>
<tr>
<td>BIF population potential specialised MHN ID (25%)</td>
<td>11,213</td>
</tr>
</tbody>
</table>

*Idescat 2016
2.2. Access to the Mental Health Network

Access to the Adult Mental Health Network (general and specialised) is governed by the following criteria:

Users must meet criteria A+B+C+D or, if they do not meet these, follow the A+B+D pattern:

A. Aged 18 or over

B. Borderline intellectual functioning, understood as a deficit in different cognitive areas (attention, language, memory, execution, knowledge, vision-perception...) that result in difficulties in the correct execution of adaptive skills and social functioning. This deficit will not be solely and etiologically secondary to mental illness. It should be noted that the cognitive deficit cannot be exclusively limited to a simple question of IQ (70-84).

C. Evidence of mental illness defined by operational criteria such as ‘any diagnosis’ included in the DSM-5 or CIE-10 classification systems.

D. Presence of one or more instances of challenging behaviour\(^2\) which, due to their intensity, frequency or duration, considerably limit the person from using community resources.

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\(^2\)Challenging behaviour is understood to be that which is socially unacceptable, the frequency, severity and duration of which may pose a physical risk to the person, to others, or to their immediate surroundings; or may significantly limit their ability to live their life in the most normal conditions possible, alienating them from more community-based environments. This represents a social construct which is not included in the usual classification systems, and which means that all alterations in a person with BIF are a challenge for the services, which must seek strategies to satisfy their complex needs.
2.3. Criteria for referring someone to the Specialised Network in Intellectual Disability

1. Clinics:
   - IQ between 70 and 84 (preferably between 70 and 75);
   - Index of Behavioural Problems (ICAP) between -31 and -35;
   - HoNOS-DI scale score ≥ 54 (Severe).

2. Social (psychosocial repercussions):

   ICAP Scale Score: ≤ 5. (periodic attention to the person and/or frequent monitoring).

   The social criteria to be used are as follows:
   - Disturbance or limitation of a function (dysfunction).
   - Functional incapacity (inability to develop a particular social role).
   - Dependence (constant need to rely on a particular person or specific service).
   - Manifest or persistent family overburdening or absence of family.
   - Absence of social network.

As indicated above, the difficulties in accessing general services may prevent people with BIF from developing and receiving the appropriate treatment. The aim of comprehensive and multidisciplinary intervention, initially coordinated by SSMHID, is to guarantee that people from this population group do not end up in 'no man's land'.

The goal to achieve over the next few years, especially with the improvement of professional skills in terms of the general network and improvements in the population register, is that the percentage of people with BIF receiving services from the general network increases progressively.
3. **Social services**

The attention and intervention provided by the Basic Social Care Teams (BSCT) respond to the social needs manifested by the family or the person with BIF.

The intervention must always be through integrated approaches, incorporating the coordination of the team and work carried out in the network with other services that provide care for the child or person with BIF, such as the primary healthcare centre, mental health services, educational institutions, local employment and housing services and any other agents.

Interventions can be carried out on an individual, group or community basis according to the care plan drawn up and its development.

In the case of BIF, the professional in charge of the case should always take into account this coordination with specialised services. It is important that this professional acts as the main interlocutor with the person, family, and other professionals involved, to ensure that the care provided is comprehensive and consistent, and to channel the different services needed appropriately.
VI. Employability
Access to the labour market is a basic right which provides human beings with self-esteem, economic security and the independence needed to build an autonomous life.

The International Labour Organisation (ILO), the main objective of which is to promote opportunities so that all people have access to productive work in conditions guaranteeing freedom and dignity, recognises that work is a fundamental element in personal satisfaction, social integration and recognition; and that having a decent quality job is the most effective way of escaping the vicious circle of marginalisation, poverty and social exclusion (International Labour Conference, Geneva, June 1999).

The Convention on the rights of Persons with Disabilities established in article 27 of the United Nations convention, recognises that people with disabilities have a right to work in equal conditions as others; this includes the right to the opportunity to earn a living by carrying out a job which has been freely chosen or accepted in a labour market and work environment that is open, inclusive and accessible to people with disabilities.

The BIF Consensus Manual exemplifies the practical experience of the employment of people with BIF in Catalonia through its contracting policies in different departments of the Catalan Government. This experience was developed through the coordinated efforts of the Nabiu Catalan Association and the representatives of the Catalan Administration.

- Government Agreement of 11 November 1997 approving a project to manage the employment of people with borderline mental deficiencies.
- Government Agreement of 21 October 1998, extending the number of workplaces provided for in the Agreement of 11 November 1997, related to the project to manage the employment of people with borderline mental deficiencies.
- Government Agreement of 15 June 1999 extending the project to manage the employment of people with borderline mental deficiencies.
- Government Agreement of 29 May 2001 extending the employment project for people with borderline intellectual disability and extending it to other groups of young people with intellectual disabilities.
- Government Agreement of 27 May 2003 extending the employment project for people with borderline intellectual disability and extending it to other groups of young people with intellectual disabilities.
- Agreement proposal of the Catalan Government approving the public employment provision for the year 2005, including 31 posts for the group and category E of general
services assistant, for permanent staff working for the Ministry of Governance and Public Administrations.

On the other hand, it is important to note that the State is responsible for establishing labour competences and that, as a result, it is the Ministry of Employment and Social Security that determines the policies to be followed, and that distributes the funds from the State's general budget to the autonomous communities to carry out active policies targeted at the whole population. In addition, it is also the State that regulates and legislates what to subsidise and how to go about doing it.

The autonomous communities have little margin to act since the fact that the budget comes from the central government means that their role is restricted to one of managing the budget they are allocated. Actions aimed at promoting employment can only be carried out with the autonomous community's budget and only after carrying out the common actions established by the Ministry of Employment and Social Security. That means that autonomous communities have little scope for activity and that the activity they carry out is subject to state control.

The aim of this working group is to elaborate recommendations to improve the employment of people with BIF.

People with BIF have special difficulties in receiving and exercising the rights they are granted under the United Nations Convention on the Rights of Persons with Disabilities. They need a period of adaptation and prior training to help adapt their potential skills to the socio-labour realities they will need to face.

An intervention process has been defined within a comprehensive approach, which means that the different departments involved in the process work together to facilitate the employment of the person.
1. Intervention process for improving employability

In order to promote the employment of people with BIF, lifelong interventions are needed that cover educational stages—when the person is being prepared to acquire the knowledge and skills needed to be able to develop as autonomous a life as possible—up to adulthood, when the person needs to find employment.

1.1. Coordination between school stage and labour stage

In accordance with the Individualised intervention plan (see chapter V) during the school stage, it is important that people diagnosed with BIF receive suitable support to enable them to make the most of their skills, as well as suitable guidance to make them aware of the training that will improve their chances of finding employment, and guidance on the employment and training resources that are the most suitable for their needs.
At secondary school, the class teacher, school advisor and/or PAT, if applicable, shall draw up a guidance document on the training opportunities available to enable people with BIF to make the transition to the labour market.

1.2. Labour stage

When the person with BIF reaches the labour stage, it is important to distinguish between those diagnosed with BIF and those that are not diagnosed.

1. People diagnosed with BIF:

The Public Employment Service (SOC) will carry out the employability questionnaire and refer the person to a specialised entity so that they can decide on the intervention needed to gain employment.

2. People with BIF without a differential diagnosis:

In such cases, it is highly likely that the problem will not be detected and that the person will not be referred to any kind of specialised entity. Because of this, it is recommended that SOC staff receive appropriate training to be able to recognise the differential traits of people with BIF and detect them in the initial interview.

In any event, to improve the opportunities of people with BIF, and to make the intervention process more efficient, the Ministry of Work, Social Affairs and Families should make every effort to ensure that people with borderline intellectual functioning (BIF) are recognised as a differential group within active employment policies.

Specifically, the Ministry's funding bids for active policies, funded by the Catalan Government, could specify the group of people with BIF as a specific group, in the same way as with other groups.

Another action to promote the employability of people with BIF would be for the Ministry to plan specific training that takes into account people with BIF.

And from the Ministry of Governance, Public Administrations and Housing, it would be worth studying the possibility of recovering and updating the project to manage the employment of people with borderline intellectual functioning initiated in 1997.
1.3. Accreditation of the BIF diagnosis

The BIF diagnosis can be accredited with a certificate issued by professionals working in ECCDC, AMHC or SSMHID, on the request of the interested party.

Also at the request of the interested party, and after presenting a certificate of the BIF diagnosis issued by a professional of the ECCDC, AMHC or SSMHID, a technical report of the BIF diagnosis with a specific assessment of the disability can be requested from the disability assessment teams of the Subdirectorate General for Attention to People and the Promotion of Personal Autonomy of the Ministry of Work, Social Affairs and Families.

People with BIF who have also been issued with a certificate indicating degree of disability may also access the resources and aid established in the regulations for people with disabilities.
VII. Interdepartmental and interprofessional coordination
1. Inter-service coordination

As explained in previous sections, the care model must be based on:

- Attention and overall assessment focused on the person, and considering the person as a co-participant and as co-responsible for the planning, developing and assessment of the care process, in line with their specific needs.

- Process of integrated assistance of all resources, adapting them to the individual needs of each moment of the process.

- Management of the case, as a methodological framework that underpins the care process and that necessarily entails a redefinition of professional leadership, the role of the key worker and shared practices.

The management of the case must be designed to provide a broad-based response to the needs of people with BIF, since different resources and professionals may need to intervene in a coordinated way to ensure the continuity of care guided by one single Individual Monitoring Plan (IMP).

Efforts must be made to ensure that all professionals of both the general and specialised network who are responsible for and authorised to act in defining and providing the necessary support work together in a multidisciplinary way to draw up the IMP.

In view of this, the figure of case manager is recommended, to coordinate between the different professionals involved in the whole process and to be the main key worker responsible for supporting the person with BIF and orienting their family.

In the case of people diagnosed with BIF and mental illness and/or additional behavioural problems, the monitoring of the case from the health sector is also appropriate.

In such cases, the manager of the case should coordinate with the local coordinator of the health sector within the context of two spaces:

- The monthly circuit meetings within the territorial framework of the Study and Referral Group (SRG).

- Regular case monitoring meetings.

The existence of a local coordinator for each health region is proposed, preferably a member of the Specialised Network in Intellectual Disability (social worker).
Functions of the local coordinator:

- Maintenance and constant updating of a register of people with BIF in the region, specifying the use of services made by each client.

- Coordination with the Child and Youth Mental Health Network when referring the case.

- Coordination with the General Mental Health Network for adults.

- Invite the people involved in attending to the individual needs of the subject to multidisciplinary territorial meetings (SRG), whether these be from the different networks (General adult, specialised, or child and youth mental health, Employment, Social Affairs and Families, Education, Justice and Third Sector), or the person affected or their legal representatives.

- Keep the individual registers for each patient up to date. These registers should include the reasons why the patient was provided with an IMP, the objectives, actions, assessments carried out, etc.

- Person to oversee the care process and coordinate and be aware of the interventions carried out by the different services and departments.

2. Recommendations on information and documentation

A shared and agile system for accessing information is needed, without compromising any aspects in terms of the confidentiality of information or in relation to the need to respect the rights of all users.

It is important that the reports issued by the different professionals involved in the process of a case include information relating to the functional aspects of the individual and that all the interventions carried out are mentioned in order to better focus and orientate the further lines of action that need to be developed.

3. Care and support for families

While respecting people's decisions at all times, the role played by the family is also important, insofar as this is the nucleus which can be key to promoting the functionality of the person diagnosed with BIF.
Families must be supported during all stages of the intervention, in order to receive the support and orientation necessary.

In all phases of the intervention it is necessary that:

- The relation of the person with the BIF diagnosis with the other people they live with is known.
- The support network that the person and their family have is known.
- The case manager provides the person diagnosed with BIF and their family with all information available (diagnosis, treatment, information on professionals).
- The family is accompanied in the referral to the services needed in each case (basic social services, specialised educational services, disability and dependency assessment teams, to manage access to certain resources if applicable).

4. Training for professionals

The availability of capable and experienced professionals is vital to improve the care given to people diagnosed with BIF.

The training of professionals in the fields of psychiatry, psychology, nursing, education, social work, direct personal care and primary care should be promoted.

With this goal, a training plan for these professionals is proposed across the whole territory. This training plan should be developed by professionals within the network specialised in people with intellectual disabilities.

Basic content of the training proposal:

- The concept of borderline intelligence functioning;
- How to detect BIF;
- The main mental illnesses in people with BIF (differences and similarities in relation to the general population);
- Integrated approach to the needs of people with BIF.

More specific training is also recommended to be able to attend to people with BIF who also
have mental illness and/or behavioural problems.

The objective is to train professionals with responsibility for care services in Mental Health for people with BIF to:

- Be aware of the main theoretical references in relation to people with BIF and mental and/or behavioural changes.
- Acquire the skills needed to assess and diagnose mental and/or behavioural changes in people with BIF.
- Acquire the skills needed to design and apply a biopsychosocial assessment which is comprehensive and effective.

5. Existing resources

This section explains the different resources involved in the processes, ordered by administration, and specifying at which age range they intervene.

Ministry of Labour, Social affairs and Families

Social Services Portfolio

Decree 142/2010 of 11 October approving the Social Services Portfolio 2010-2011.

The Social Services Portfolio is targeted at people in situations with special needs, such as, among others, dependent people or those with disabilities, mental illness, drug dependency and other additions, at risk of violence or youth crime, or subject to penal measures, disadvantages, risks or social difficulties experienced by the elderly, children or adolescents, exclusion or social emergencies, victims of sexism, discrimination or poverty.

It should be noted that people diagnosed with BIF with no other diagnoses are not granted disability status or dependency status, according to the provisions of current legislation.

Therefore, it is important to highlight that people need to have been recognised as having at least 33% disability in order to access residential resources or programmes. This assessment is carried out by the assessment and orientation services. These services are made up of assessment teams distributed across the whole of Catalonia.
If a person has been recognised as having the required level of disability as well as dependency, the residential resources to which the person meeting this criteria can access are as follows:

- Daytime care services for people with intellectual disabilities;
- Autonomy promotion services at home for people with intellectual disabilities;
- Residential care services for people with intellectual disabilities.

**Catalan Employment Service - Training**

Manages different measures, one of these being employment training. In this respect, they offer courses targeted at unemployed people registered at Employment Offices of the Government of Catalonia, programme pilot actions in new qualifications, and carry out occupational tests to assess professional competence and issue the corresponding certificates.

The main objective of the body is to be a source of reference within the field of employment for both employed and unemployed workers.

It is important to note the recent Government Agreement 49/2016 of 26 April, approving the directives of the Professional Accreditation and Qualification Plan which is to be developed.

**Directorate General of Social Economy, the Third Sector, Cooperatives and Self-employment - Employment**

Manages employment insertion measures for people with disabilities and/or mental illness, through subsidies for non-profit organisations and foundations and local corporations specialised in this task.
Ministry of Education

**Educational Institutions**

Information on educational institutions can be found at the Ministry of Education website:

http://ensenyament.gencat.cat/ca/inici/

**Psychopedagogical Assessment and Orientation Teams (PAT).**

PATs are assessment and psychopedagogical orientation teams that provide support for teachers and schools in order to attend to student diversity and to students who present special educational needs, as well as their families.

Ministry of Health

**CYMHCs, AMHCs, and SSMHIDs**

CYMHCs during childhood and youth and AMHCs and SSMHIDs during adulthood act as a Primary Care Service of the Mental Health Network and are the gateway into this network. These centres play a central role in providing care and assessment, for coordinating the case once it has been assessed, and for deciding on the intervention needs in relation to other resources:

- Day hospitals: partial hospitalisation resource for daytime care;
- Acute and Sub-acute Hospitalisation Units with full internment;
- Day Centres / Rehabilitation Services: intervention resources to improve relationship skills and functional activities related to community life;
- SHUID: Specialised hospitalisation unit for persons' with intellectual disabilities in collaboration with Social Affairs;
- Care Centres for drug-dependency (DDCC) in pathological situations of comorbidity with substance abuse.

Alongside the Collaboration Programme established with the Primary Health Services, the MHS coordinate to ensure intervention with the most suitable resources for each individual.
Ministry of Justice

Institute of Legal Medicine and Forensic Sciences of Catalonia.

The Institute is regulated by the following provisions:

Decree 411/2006 of 31 October, approving the Regulations of the Institute of Legal Medicine of Catalonia. DOGC no. 4753.

Decree 279/2016 of 2 August, modifying the Regulation of the Institute of Legal Medicine of Catalonia, approving Decree 411/2006 of 31 October, and its denomination as the Institute of Legal Medicine and Forensic Sciences of Catalonia.7177.

Graph summarising existing resources.
VIII. Glossary
Adult Mental Health Centres (AMHC)

These are outpatient care services specialised in psychiatric care and mental health for people over 18 who present mental disorders in any of the developmental stages of mental illness who, due to the seriousness and/or complexity of their case, require additional care to that provided through the primary healthcare services (PHS).

They also support the primary health services through illness prevention programmes and by carrying out research and delivering teaching programmes in mental health.

A Ministry of Health service.

Attention to Diversity Team

This is the institutional space in which the school's measures for attending to student diversity is planned, where the monitoring of these measures takes place, and where changes are reviewed and promoted to improve the performance, state of well-being and success of all students.

The team comprises the management team; the teachers specialised in attention to diversity, special education teachers, the school adviser, therapeutic pedagogy teachers, support teachers, teachers from the linguistic support class, professionals from the Special Education Support Unit (SESU); the psychopedagogue of the assessment and psychopedagogical guidance team (PAT) and the coordinators or representatives of the different teaching teams or stages, depending on the educational stage.

A Ministry of Education service.

Basic Social Care Teams (BSCT)

The basic social care service comprises a set of professional actions that aim to attend to the most immediate, general and basic social needs of individuals, families and groups.
These actions also help prevent social problems and promote the reintegration of people at risk of social exclusion.

The main functions of the technical teams that offer this service are:

- To provide information, guidance, advice, community social work, social and educational detection, prevention and treatment.

- To make care proposals for people and for the community, to design programmes of social actions, and to cooperate with other services in the well-being network.

- To have knowledge of the existing resources and social provisions available and to provide information and help individuals carry out formal procedures.

This is a municipal service

**Borderline intellectual functioning (BIF)**

Borderline intellectual functioning (BIF) is a condition that affects a considerable proportion of the population, impacting on people’s quality of life and on their social and labour inclusion. Despite its social impact and frequency, BIF is still not sufficiently recognised by health, social, education, labour and legal systems at an international level.

**Care Centre for Persons with Disabilities (CCD)**

Care centres for persons with disabilities (CCDs) provide information and guidance services for people with disabilities, for their families, and for the community of professionals who require such information. They are distributed across Catalonia and each centre is allocated a specific area of influence.

The centres host the assessment and orientation teams (LAOT), composed of multi professional teams made up of a
director, doctor, psychologist, social worker and administrative personnel.

**Catalan Public Employment Service (SOC)**

In accordance with Law 13/2015 of 9 July, in relation to the employment system and the Catalan Public Employment Service, the SOC is an autonomous body with an administrative scope, assigned to the Ministry of Work, Social Affairs and Families of the Government of Catalonia.

The work carried out by the SOC is framed within the European Employment Strategy and the national plans for work established by the State.

The main functions of the SOC are:

- To offer and provide services to anyone looking for work, whether they are currently employed, unemployed, or working for a company.
- To offer a framework of equal labour opportunities for all.
- To foster an entrepreneurial spirit and provide support for small and medium-sized businesses.
- To ensure that dialogue and commitment among public and private agents acts as the main driving force of employment policies.
- To achieve high levels of employment through proactive efforts, along with the promotion and creation of jobs.

**Certificate of degree of disability**

The resolution on the recognition of degree of disability (commonly recognised certificate) is the administrative document that certifies a person’s disability status. This document facilitates the person's access to different rights, services, programmes and services that aim to redress the social disadvantages arising from their disability, or the social barriers that limit their full and effective participation in society.

In order to be able to access benefits for people with disabilities, the individual must be recognised with a disability level of 33% or more.
The degree of disability is expressed as a percentage and is carried out by applying Royal Decree 1971/199 of 23 December on the procedures for recognising, declaring and qualifying degrees of disability.

An assessment is made of physical, mental, and sensory disabilities and the communication and speaking skills presented by the person, as well as any additional social factors related to their family context, labour situation, or education and cultural background that could hinder their social integration.

Child and Youth Mental Health Centres (CYMHC)

These are outpatient care services specialised in psychiatric care and mental health for people under 18 who present mental disorders in any of the developmental stages of mental illness who, due to the seriousness and/or complexity of their case, require additional care to that provided through the primary healthcare services (PHS).

This service is included in the care system, being linked to the other resources and with a coordination system that facilitates ongoing care within the patient's therapeutic plan.

A Ministry of Health service.

Diagnostic classification

Clinical diagnostic category / Secondary category

The Classificació estadística internacional de malalties i problemes relacionats amb la salut, 10a revisió (CIM-10), is the Catalan translation of the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10), of the World Health Organisation (WHO).

In Catalonia, the ICD-10 is mainly used to code causes of death, as well as illnesses and health problems treated at primary healthcare centres (PHCs) and primary healthcare emergency services (A&E), among others.

This classification is part of the diagnostic and procedures catalogue of the Systems Plan of the Catalan Health
Service.

**DSM-5**

The Diagnostic and Statistical Manual of Mental Disorders, DSM) of the American Psychiatric Association, or APA, contains a classification of mental disorders and clear descriptions of the diagnostic categories, to help clinics and health science researchers diagnose, study and exchange information to treat different mental disorders.

The current edition is the fifth - DSM-5 - which was published on 18 May 2013.

**Early Childhood Care and Development Centres (ECCDC)**

Centres specialised in the comprehensive care of children up to six years old with development difficulties or disorders, or at risk of suffering from them. As public care services, they are available across the whole of Catalonia and work in coordination with the other resources involved in providing primary care for children.

Today, there are eighty six ECCDCs (including full-time and part-time services, i.e. services that provide attention one day a week) across the whole of Catalonia.

This service belongs to the Ministry of Work, Social affairs and Families.

**Hospitalisation unit specialised in persons with intellectual disabilities (HUSID)**

A highly specialised hospital unit. The unit cares for adults with intellectual disabilities who also present serious mental and/or behavioural disorders.

**Idescat**

The Statistical Institute of Catalonia (Idescat) is the body responsible for official statistics in the region of Catalonia. Created in December 1989 (Decree 241/1989 of 11 December). At present it comes under the Ministry of the Vice-presidency and of the Economy and Finance, of the
Government of Catalonia.

**Intellectual disability (ID)**

Arising from significant limitations in intellectual functioning, in adaptive behaviour and practical skills. It is characterised by intellectual functioning below the mean, together with limitations in two or more of the following areas of adaptation skills: communication, taking care of oneself, home life, social skills, use of the community, self-management, health and safety, functional school contents, leisure and work.

**Intelligence quotient (IQ)**

Intelligence quotient (IQ) is a score obtained after carrying out a standardised test to measure cognitive skills and the intellectual capacity of a person (intelligence) in relation to their age group. It is expressed in such a way that the mean IQ of an age is 100 (a person with an IQ of 110 is therefore above the mean of their age group; and a person with an IQ of 90 is below the mean of their age group). The most normal case is that the standard deviation (σ) of the results is between 15 and 16, and the tests are designed in such a way that the distribution of the results follows a Gaussian distribution, which is to say that it follows a normal curve.

**MH&AN - Mental Health and Addictions Network**

The Mental Health and Addictions Network is the public network specialised in providing mental health care. It provides total or partial hospitalised care and community care services that are provided through adult and children mental health centres and addictions centres or community rehabilitation centres.

**Primary Health Service (PHS)**

The Primary Healthcare Service is the first point of access to the public health system. Patients are referred to other services provided by the system from the primary care service, except in the case of 061 CatSalut Respon or through medical emergencies, which patients can access.
directly in the case of an emergency.

The Primary Healthcare Centre (PHC) is the place where individuals should go when they have a health problem or want to prevent an illness. The centre attends to and diagnoses the main health problems, health and social care, and health promotion services, preventative care, curative care and rehabilitation, home care services, emergency or ongoing care, and sexual health and reproductive care.

Primary healthcare services are part of the basic common portfolio of care services which are completely covered by public financing.

The primary care team (PAT) is the whole team of family medicine professionals, including paediatrics, nurses, dentists, social workers and citizens' advisers, who are trained to offer comprehensive care, including the care and promotion of health and education in healthy habits, the prevention of illness, and guidance in relation to social care.

A Ministry of Health service.

Psychopedagogical Assessment and Orientation Teams (PAT).

PATs are assessment and psychopedagogical orientation teams that provide support for teachers and schools in order to attend to student diversity and to care for students who present special educational needs, as well as their families.

They are part of the Local Educational Services (LES), together with the pedagogical resource centres (PRC) and the Language, Intercultural and Social Cohesion Assessment Teams (LISCT).

They provide services for schools, management teams, teachers and other professionals involved in caring for students with difficulties or special educational needs and their families.

A Ministry of Education service.
| **Social Commission** | An interdisciplinary space that arises from the Diversity Attention Team, where a record is kept of the demands detected at school or in other services, as well as of any social problems manifested, and where analysis and reflection is carried out to agree on the diagnosis, decide on suitable intervention and establish a monitoring process.  
A Ministry of Education service. |
| **Special Education Support Unit (SESU)** | These are resource units (human, technical and material) that support schools to help them in the process of attending to students with special educational needs in mainstream schools. |
| **Specialised service in mental health for people with intellectual difficulties (SSMHID)** | These are outpatient care services specialised in psychiatric care and mental health for people of any age who present mental disorders in any of the developmental stages of mental illness who, due to the seriousness and/or complexity of their case, require additional care to that provided through the primary healthcare services.  
This service is included in the care system, being linked to the other resources and with a coordination system that facilitates ongoing care within the patient’s therapeutic plan.  
It focuses its attention on patient and family care, but also provides support for the care teams of special educational centres and employment teams.  
A Ministry of Health service. |
| **Study and Referral Group (SRG)** | A mixed body that coordinates the study and assessment of the needs of people with ID who present mental disorders or behaviour in each health region, and that decides to refer them to more suitable resources when the seriousness of the case requires. |
**Ministries of the Government of Catalonia**

These are the four ministers of the Catalan Government that are included in this document:

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IX. Bibliography


