Royal College of Speech and Language Therapists (RCSLT)

Mental Health Strategy for Scotland 2011-15 – A Consultation

Substantive Response

See below for response to CONSULTATION QUESTIONS

RCSLT Position:

- RCSLT recognise that there are a few isolated examples of SLT best practice in Scotland which should be built on as part of the mental health strategy 2012-15.

- However the SLCN of Scotland's mental health service users, both actual and "at risk", are far from being met within current resources.

- The lack of provision of services for SLCN within mental health services (through provision of SLT) constitutes a very serious weakness in the strategy to enhance mental well being and reduce mental illness in Scotland.

- Actual and "at risk" MH service users need a strategic response to SLCN. See RCSLT recommendations on what that might be below.

Key facts:

- Consensus across several sources of evidence indicates up to 8/10 mental health service users will have speech, language and communication difficulties or needs (SLCN) – that is a permanent or transient difficulty understanding the spoken and / or written word and / or expressing themselves effectively verbally, non-verbally and / or in writing.

- SLCN are a risk factor for mental illness - contributing significantly for example to social exclusion and undermining protective factors such as access to employment.

- There are exceptionally high levels of SLCN among those with developmental disorders or those who have experienced trauma, e.g. 50% of 5yr olds entering school from deprived communities; 80% or more of people with learning disabilities; looked after children and young people; 60% of young offender populations; children who have experienced abuse; 33% of people who have had a stroke; brain injured;; substance abusers etc.

- Person centred, safe and effective, patient experiences are dependent on effective two way communication, whether face to face or written, between service providers and actual or potential service users.

- The following relevant standrads, frameworks and guidelines are just some of the previously published evidence based materials which recognises key speech and language therapists (SLT) roles in mental health -*Realising Potential*, an *action plan for allied health professions in mental health; Standards of Care for Dementia; Promoting Excellence (all four skills levels);*

Adults with Incapacity Act Codes of Practice; Adult Support and Protection guidance; Integrated Care Pathways for mental health evidence base, CAMHS Framework; SIGN 30 Psychosocial interventions in the management of schizophrenia; SIGN 82 Bipolar effective disorder; SIGN 112 Management of attention deficit and hyperkinetic disorders in children and young people; Health Improvement Scotland Admissions to adult mental health inpatient services - Best Practice Statement; Royal College of Psychiatrists guidelines', "Every child is special, framework for mental health".

- There is a strengthening evidence base which exposes the roles and positive impact of SLT in mental health services. RCSLT is in the process of developing a position paper on SLT in mental health which collates this evidence. A summary of evidence is attached to this response. Although compiled a few years ago, in the ansence of the RCSLT position paoer, it provides a goodsummary of evidence available in 2007.

- Despite the high incidence of SLCN among those accessing mental health services and some awareness of the positive impact of SLT there are currently only an estimated 5.5 whole time equivalent speech and language therapy posts dedicated to this care group for the whole of the Scottish population.

Reasons for the serious gap in provision for SLCN in Scotland's mental health care strategy – a "chicken and egg"story

- Low levels of awareness or knowledge of the nature, incidence and impact of SLCN in the actual and "at risk" mental health population – other than perhaps SLCN arising from hearing impairment. Specific action on mental health within the deaf community addresses the needs of only a minority of the estimated 250,000 Scots with SLCN.
- Low levels of awareness of the role and impact of SLT.
- Low levels of awareness of best practice in managing SLCN across the mental health and wider public and other sectors workforce.
- The low awareness described has meant there is practically no capacity for viable strategic or operational level action to address the gap between SLC needs and provision. Even where *Realising the Potential* and the related *AHP Mental Health Workforce Scoping* exercise report recommends action in reality the small capacity of the few SLTs working in mental health is so stretched is that effective take up of recommendations has proved impossible. Scotland's recognised leading SLT in mental health recently had to stand down from co-chairing the *Realising Potential* implementation group due to commitments in her local area. The RCSLT supported MH Special interest Group has ceased to operate as it's extremely committed and enthusiastic members cannot get the release time to participate in activities designed to raise awareness of SLCN in mental health.
- Lack of awareness and subsequent lack of sustained and sustainable capacity to change that SLCN awareness ultimately means there is very little (and even shrinking) national or local resource dedicated to meeting SLCN of actual or "at risk" MH service users.

RCSLT recommended strategic response to SLCN actual and "at risk" MH service.

RCSLT would recommend the mental health strategy includes commitments to;

1. Build on SLT evidence base and work so far in mental health services in Scotland, elsewhere in the UK and across the world.

2. Viable, sustainable and sustained SLCN and SLT role awareness raising activity.

3. A sustained (3-5 year) pilot project, in at least one health board area, aimed at developing a quality, viable SLCN service model to incrementally inform and support local delivery of SLCN solutions across Scotland.

   A SLCN service model would incorporate;

1. Universal level provision:
   Implementation of a communication access standard for all services responsible for delivery of the MH strategy – optimising communication access to all levels of mental health services. A quality communication access standard would support provision of accessible printed and on line information relevant to delivery of all outcomes (particularly priority groups); quality face to face interaction which was sensitive to the diversity of SLCN and development of SLCN sensitive care environments.

   Scottish Government Equality Fund has and will in the future support development and implementation of Inclusive Communication Standards within public services. Local implemenation of these is dependent In part on local partnerships of which SLTs form a key part.

2. Targeted level provision:
- Integrated, quality SLCN screening
- Skills transfer across the wider mental health sectors workforce to enable SLCN sensitive delivery of Levels 2,3 and 4 care.

3. Specialist level provision:
- Access to detailed SLT assessment and, where necessary, SLT treatment programmes delivered 1:1 or in groups as part of level 1-4 care.

Special focus on SLT in an AHP world
Realising Potential makes welcome recommendations for action by the AHP workforce. However in order for SLTs to act on the recommendations there need to be SLTs available to do the work. The AHP Workforce Scoping exercise strikingly showed there simply are not the SLTs on the ground with the autonomy, flexibility and capacity to take recommendations forward. A relatively small amount of "pump priming" would create a more even playing field for the SLTs to act, on behalf of service users with SLCN, in unison with their bigger, better resourced, more dominant AHP colleagues.

CONSULTATION QUESTIONS

Overall Approach

This consultation reflects a continuation and development of the Scottish Government's currept approach for mental health. There Is a general consensus that the broad direction is right but we want to consult on:

- The overall structure of the Strategy, which has been organised under 14 broad outcomes and whether these are the right outcomes;
- Whether there are any gaps in the key challenges identified;
- In addition to existing work, what further actions should be prioritised to help us to meet these challenges.

Comments

Overall Structure and are they the right outcomes?

- Priorities are supported by RCSLT.
- Outcomes appear relevant.

Any gaps in key challenges?

- Comprehensive, quality response to speech, language and communication needs. See RCSLT Substantive Response above.

Improvement Challenge Type 1

We know where we are trying to get to and what needs to happen to get us there, but there are significant challenges attached to implementing the changes. An example of this is the implementation of the Dementia Strategy. There is a consensus that services for people with dementia are often not good enough and we already know about a range of actions that will improve outcomes. However some of these changes involve redesigning the way services are provided across organisational boundaries and there are significant challenges attached to doing this.

Question 1. In these situations, we are keen to understand whether there is any additional action that could be taken at a national level to support local areas to implement the required changes.

Comments

RCSLT believe the Issues around SLCN provision fall primarily in to challenge type 2 – See RCSLT Substantive Response above.

Improvement Challenge Type 2

We know we need to improve service provision or that there is a gap in existing provision, but we do not yet know what changes would deliver better outcomes. Supporting services to improve care for people with developmental disorders or trauma are two areas where further work is needed to identify exactly what needs to happen to deliver improved outcomes.

Question 2: In these situations, we are keen to get your views on what needs to happen next to develop a better understanding of what changes would deliver better outcomes.

Comments

RCSLT believe the Issues around SLCN provision fall primarily in to challenge type 2 – See RCSLT Substantive Response above.

14 Mental Health Strategy Outcomes

Outcome 1: People and communities act to protect and promote their mental health and reduce the likelihood that they will become unwell.

Question 3: Are there other actions we should be taking nationally to reduce self harm and suicide rates?

Comments

Public information aimed at promoting self management should be SLCN sensitive.

Wellscotland.Info, for example, is not communication accessible to people with SLCN including those with literacy difficulties.

Reducing Self Harm:
People who self harm will not normally find it easy to communicate about self harm generally. For people who self harm and have a SLCN this is an even bigger barrier to seeking and getting help.

Self Harm Reduction programmes should be speech, language and communication needs (SLCN) sensitive.

Suicide:
SLCN are extremely common among young people who offend (consensus figure is 60% of the YO population). It is understood by RCSLT that suicide is relatively high among people on remand. "Reducing suicide" activity therefore should recognise and effectively respond to the SLCN of target groups if it is "to get through" to these groups.

Suicide Reduction programmes should be speech, language and communication needs (SLCN) sensitive.

RCSLTrecommend Implementation of a communication access standard.

See RCSLT Substantive Response above.

Question 4: What further action can we take to continue to reduce the stigma of mental illness and ill health and to reduce discrimination?

Comments
Eliminating Stigma, reducing discrimination: Reduce the stigma and discrimination experienced by those who have difficulty communicating in the way "society" expects them to - that is those with SLCN, the majority of MH service users and an estimated 250,000 Scots. RCSLT recommend Implementation of a communication access standard. See RCSLT Substantive Response above.

Question 5: How do we build on the progress that see me has made in addressing stigma to address the challenges in engaging services to address discrimination?

Comments
See above

Question 6: What other actions should we be taking to support promotion of mental wellbeing for individuals and within communities?

Comments
Make the link between Intermediate Qutcomes (e.g. social connectedness, social inclusion, employment) in the MH Outcomes Framework and effective speech, language and communication competence. RCSLT recommend this could be acheived via a Viable, sustainable and sustained SLCN and SLT role awareness raising activity. See RCSLT Substantive Response above.

Outcome 2: Action is focused on early years and childhood to respond quickly and to improve both short and long term outcomes.

Question 7: What additional actions must we take to meet these challenges and improve access to CAMHS?

Comments
Ensure wide recognition of SLCN of child and / or parent as a risk factor for mental illness in early childhood and later life. Evidence shows a relationship between SLCN and later personality disorder, attachment disorders, challenging behaviour (all ages) and inoidence of mental illness risk factors. See SRU report No. 34/2007 ;

Communication Support Needs: A Review of the Literature and subsequent research linking childhood SLCN and llife outcomes.

Ensure investment in CAMHs addresses gaps across the CAMHs workforce particularly those exposed as weakest in number (i.e. SLT) in the Allied Health Professionals in Mental Health Workforce and Education Priorities Scoping Report to Scottish Govt. and NES, July 2010.

Ensure parenting programmes integrate expertise of SLTs to develop skills to assess development of parent-child communication and to optimise child's speech, language and communication development - whatever the parent and child's communlcation and learning potential. (See description of Targeted Level Provision in RCSLT Substantive Response). information on SLT engagement in parenting programmes (including Triple P) across Scotland suggests patchy, short term or vulnerable provision even where very positive progress has been reported. information on SLT engagemwent with Parenting Programmes is available on request fom RCSLT.

See RCSLT Substantive Response above.

Question 8: What additional national support do NHS Boards need to support implementation of the HEAT target on access to specialist CAMHS?

Comments

Universal, targeted amd specialist levels of SLT provision dedicated to CAMHs would facilitate both access to services as well as increasing effective "throughput".

See RCSLT Substantive Response above.

Outcome 3: People have an understanding of their own mental health and if they are not well take appropriate action themselves or by seeking help.

Question 9: What further action do we need to take to enable people tb take actions themselves to maintain and improve their mental health?

Comments

Breathing Space and other self management resources and initatives focused on "mental health literacy" must be SLCN sensitive if they are to reach groups most likely to appear in mental health services. Any service which requires the potenrial service user to read, write (on line) or speak on the phone clearly has to accommodate the needs of these that can't do that easily or effectively.

See RCSLT Substantive Response above particularly the recommendation on Universal level provision.

Question 10: What approaches do we need to encourage people to seek help when they need to?

Comments

See above.

Outcome 4: First contact services work well for people seeking help, whether in crisis or otherwise, and people move on to assessment and treatment services quickly.

Question 11: What changes are needed to the way in which we design services so we can identify mental illness and disorder as early as possible and ensure quick access to treatment?

Comments

SLCN should be identified (and differentiated from a mental illness diagnosis as often happens) as early as possible on entry to the care pathway so that all further provision can respond sensitively to the individuals SLCN.

Integrated SLCN screening (as part of Targeted Level SLt provision), a more general communication access standard and targeted SLT skills transfer /staff training would enable this.

See RCSLT Substantive Response above.

Outcome 5: Appropriate, evidence-based care and treatment for mental illness is available when required and treatments are delivered safely and efficiently.

Question 12: What support do NHS Boards and key partners need to apply service improvement approaches to reduce the amount of time spent on non-value adding activities?

Comments

Service providers need to be made aware of the impact of SLCN on the service users ability to access and / or benefit from services. Support to Identify communication access barriers and training to enact evidence based solutions to overcome these would facilitate SLCN sensitive service improvement.

See RCSLT Substantive Response above.

Question 13: What support do NHS Boards and key partners need to put Integrated Care Pathways into practice?

Comments

NHS Boards would benefit from an improved capacity to Include of all those professional groups who have contributed to the evidence base underlying the ICPs in their application and evaluation.

For example, SLCN related evidence informs ICPs for CAMHs, depression and Schizophrenia however few, if any SLTs, are engaged in local implementation due to the severe capacity restraints described above.

See RCSLT Substantive Response above.

Outcome 6: Care and treatment is focused on the whole person and their capability for growth, self-management and recovery.

Question 14: How dp we continue to develop service user involvement in service design and delivery and in the care provided?

Cpmments

Enable SLTs to learn from and contribute their knowledge and expertise to the Scottish Recovery Network.

Communicate link between SRi 2 reflective questions and indicators and optimum speech, language and communication competences – and subsequently raise awareness of the role of SLTs In enabling people to achieve optimum SLC competence – via universal, targeted and speciailist SLT service provision.

Ensure slef management intiatives are SLCN responsive.

Implement a Communication Access Quality standard – as covered in RCSLT Substantive Response above.

Question 15: What tools are needed to support service users, families, carers and staff to achieve mutually beneficial partnerships?

Comments

Ensure service provder / staff communication is responsive to the SLC needs of service user / care / family.

Implement a Communication Access Quality standard – as covered in RCSLT Substantive Response above.

Question 16: How do we further embed and demonstrate the outcomes of person-centred and values-based approaches to providing care in mental health settings?

Comments

See RCSLT Substantive Response above.

Question 17: How do we encourage implementation of the new Scottish Recovery Indicator (SRI)?

Comments

See answer to question 14 above.

Question 18: How can the Scottish Recovery Network develop its effectiveness to support embedding recovery approaches across different professional groups?

Comments

Enable SLTs to secure the opportunity to engage with the network.

See RCSLT Substantive Response above.

Outcome 7: The role of family and carers as part of a system of care is understood and supported by professional staff.

Question 19: How do we support families and carers to participate meaningfully in care and treatment?

Comments

Provide SLCN sensitive carer support. That is ensure Care Support initiatives apply the same Communcation Access support standard as direct services to service users.

Enable prpvision of SLT services.

Social skills training improves relationships of schizophrenic patients with their families.(Leff, J. (1994) Working with the families of schizophrenic patients. *British Journal of Psychiatry 164*, 23, 71-76.)

*There is evidence that carers find behavioural and communication problems more stressful than aspects of Activities of Daily Living (ADL) and self care impairments (*Haley WE, Wadley VG, West CAC and Vetzel LL. (1994). How care-giving stressors change with severity of dementia. *Seminars in speech and language*; 15:3, 195-205.)

See RCSLT Substantive Response above.

Question 20: What support do staff need to help them provide information for families and carers to enable families and carers to be involved in their relative's care?

Comments

See answer to questlon19 above.

Outcome 8: The balance of community and inpatient services is appropriate to meet the needs of the population safely, efficiently and with good outcomes.

Question 21: Hbw can we capitalise on the knowledge and experience developed in those areas that have redesigned services to build up a national picture of what works to deliver better outcomes?

Comments

See RCSLT Substantive Response above. A pilot SLT service model would, we recommend extend to all service locations.

Outcome 9: The reach of mental health services is improved to give better access to minority and high risk groups and those who might not otherwise access services.

Question 22: Hipw do we ensure that information is used to monitor who is using services and to improve the accessibility of services?

Comments

Extend the national coommunlty mental health and sensory impairment services so they reach the whole population of people with SLCN - of which people with sensory impairment are a minority group. Developing MH services which only reach certain SLCN groups, aalthough clearly welcome, is agruably discriminatory towards other groups of people with SLCN but no sensory impairment.

See RCSLT Substantive Response above.

Question 23: How do we disseminate learning about what is important to make services accessible?

Comments

It is notable that the strategy document itself only recognises SLCN related to sensory impairment and speakers of languages other than English.

This demonstrates the low levels of awareness or knowledge of the nature, incidence and impact of SLCN in the actual and "at risk" mental health population – other than perhaps SLCN arising from hearing impairment. Specific action on mental health within the deaf community addresses the needs of only a minority of the estimated 250,000 Scots with SLCN.

See RCSLT Substantive Respdnse above.

Question 24: In addition to services for older people, developmental disorders and trauma, are there other significant gaps in service provision?

Comments

Quality mental health provision for the broad population of people of all ages with SLCN.

See RCSLT Substantive Response above.

Outcome 10: Mental health services work well with other services such as learning disability and substance misuse and are integrated in other settings such as prisons, care homes and general medical settings.

Question 25: In addition to the work already in place to support the National Dementia Demonstrator sites and Learning Disability CAMHS, what else do you think we should be doing nationally to support NHS Boards and their key partners to work together to deliver person centred care?

Comments

SLTs are key members of Learning Disability and Additional Support Needs (Children and young People) services. SLT are also recognised in the Dementia Standards document, for example, as having key roles in Dementia Care Pathways. Enabling sustainable inclusion of SLT leaders (and AHP leads more generally) in the intiatlves listed in the strategy document would represent progress.

Progress could be made further by central government support for the introduction of many more dementia and mental health AHPs - including SLTs, as has been done for other members of the multri-disciplinary care team (i.e. nurses).

See RCSLT Substantive Response above for a suggested incremental approach to this improvement.

Question 26: In addition to the proposed work in acute hospitals around people with dementia and the work identified above with female prisoners, are there any other actions that you think should be national priorities over the next 4 years to meet the challenge of providing an integrated approach to mental health service delivery?

Comments

SLCN are disproportionately recorded in the prison population. For example 40% of female offenders and 60% of young offenders have an SLCN

Recommendation set out in the RCSLT Substantive Response above are therefore relevant here.

Outcome 11: The health and social care workforce has the skills and knowledge to undertake its duties effectively and displays appropriate attitudes and behaviours in their work with service users and carers.

Question 27: How do we support implementation of *Promoting Excellence* across all health and social care settings?

Comments

Enable SLTs to access and contribute expertise to training opportunities.

See RCSLT Substantive Response above.

Question 28: tn additipn to developing a survey to support NHS Boards' workforce planning around the psychological therapies HEAT target – are there any other surveys that would be helpful at a national level?

Comments

Survey on the capacity of the mental health workforce to deliver SLCN sensitive services- including SLCN sensitive psychological services. This would enable assessment of the scope and nature of action required tp deliver truely communication accessible services- and establish a baseline of good practice from which to build.

Question 29: What are the other priorities for workforce development and planning over the next 4 years? What is needed to support this?

Comments

RCSLT would recommend the mental health strategy includes commitments to;

1. Build on SLT evidence base and work so far in mental health services in Scotland, elsewhere in the UK and across the world.
2. Viable, sustainable and sustained SLCN and SLT role awareness raising activity.
3. A sustained (3-5 year) pilot project, in at least one health board area, aimed at developing a quality, viable SLCN service model to incrementally inform and support local delivery of SLCN solutions across Scotland.

See RCSLT Substantive Response above.

Question 30: How do we ensure that we have sustainable training capacity to deliver better access to psychological therapies?

Outcome 12: We know how well the mental health system is functioning on the basis of national and local data on capacity, activity, outputs and outcomes.

Question 31: In addition to the current work to further develop national benchmarking resources, is there anything else we should be doing to enable us to meet this challenge.

Comments

In RCSLT Substantive Response above we recommend a pilot project to develop an SLCN service model. If this pilot were to be supported in one health board area it would be essential to compare impact on benchmarking data.

RCSLT would wish to see indicators of interest to service users with SLCN incorporated In to balanced scorecards for dementlaa and CAMHs services given the level of SLCN within these care groups. At the time of writing it is not clear if this is the presently the case.

Question 32: What would support services locally in their work to embed clinical outcomes reporting as a rputine aspect of care delivery?

Comments

Project work to facilitate integration and monitoring of intermediate outcomes (from MH Outcomes Famework) as part of service delivery.

Outcome 13: The process of improvement is supported across all health and social care settings in the knowledge that change is complex and challenging and requires leadership, expertise and investment.

Questipn 33: is there any other action that should be prioritised for attention in the next 4 years that would support services to meet this challenge?

Comments

RCSLT recently published a health economilsts analysis of the impact of quality SLT provision – available from RCSLT on request.

Focusing on 4 care groups including dysphagia (eating, drinking and swaollowing difficulties present in dementia) and children and young people with SLCN the independent report found that speech and language services deliver a net benefit to the Scottish economy of £61.2 million each year.

RCSLT are keen that NHS boards recognise the positive impact of SLT services on productivity and efficiency.

RCSLT Substantive Response above recommends both an awareness raising exercise and development of a (costed) service model.

Question 34: What specifically needs to happen nationally and locally to ensure we effectively integrate the range of improvement work in mental health?

Comments

Support full professional engagement (including SLT) with the extensive information and initiatives around mental health. This would require, in relation to SLT, supporting release from direct care for CPD.

See RCSLT Substantive Response above for information on challenges currently preventing this release.

Outcome 14: The legal framework promotes and supports a rights based model in respect of the treatment, care and protection of individuals with mental illness, learning disability and personality disorders.

Questipn 35: How do we ensure that staff are supported so that care and treatment is deliyered in line with legislative requirements?

Comments

Adults with Incapacity Act, Mental Health Act and the Adult Suppprt and Protection Act all have common underlying principles, (e.g. optimum involvement In decision making) the delivery of which are dependent on effective two way communication between service provider and recipient.

SLTs are identified within the Adults with Incapacity Codes of Practice as specialist in assessing and advising on capacity to understand and communcate informed decusions. The same principles regarding optimising communication aisp apply to implemehation of the MH Act.

SLTs are also very active in Adult Support and Protection. The scottish Govt. has, cover the last 2-3 years funded SLTs to lead ASP projects to ensure people with SLCN enjoy equal rights under the ASP Act.

RCSLT would recommend the SLTs are enabled to effectively support their multidisciplinary colleagues to meet the Acts above – and more generally the Equality and Human Rights Act and Disability Equaality Duties.

Such support, we would suggest, would form a central role in a comprehensive SLCN service as outlined in RCSLT Substantive Response above.

ROYAL COLLEGE OF SPEECH & LANGUAGE THERAPISTS

Speech and Language Therapy in Mental Health Services[1]

Briefing paper Feb. 2007

A: Why SLTs have a role in mental health services

i) Needs of service users and skills of SLTs

Speech and Language Therapists (SLTs) are dedicated to the needs of people with communication support needs (or impairment) and eating, drinking and swallowing difficulties (dysphagia).

A high number of people accessing mental health services in the community or hospitals present with significant communication support needs and / or dysphagia.

62% of children in psychiatric populations had speech and language impairment. 28% had previously been identified with 34% previously undetected. (Goodyer, 2000; Cohen 1993)

38% of children referred to child psychiatric services met one or more criteria for a previously identified language impairment while 41% met criterion for unsuspected language impairment. In total 63.6% of children referred had a language impairment.(Cohen et al. 1998) ?1989

Of 62 attendees at area psychiatric services 84% had a language impairment and 74% had communication and discourse problems. "Clearly, impairment of communication and /or language may compound the negative experience of psychiatric illness, as well as offering insights in to the origins of psychiatric symptoms" (RCP, 2004).

Communication disorder becomes apparent during the course of all types of dementia varying according to disease type, duration and other factors including pre-morbid skills and environment (Bryan & Maxim, 1996).

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[1] Sources of evidence referenced in this brief include;

- RCSLT Clinical Guidelines
- RCSLT Communicating Quality 3
- RCSLT Position Paper on SLT Provision for People with Dementia
- Presentations given by practitioners at RCSLT Mental Health Network (MHN) launch, June 2006
- Literature collated by RCSLT Mental Health Network (Scotland) and MH Special Interest Group (England)
- RCSLT Accredited Specialist Adviser in MH
- Authors of relevant literature.

Studies that look at the incidence of swallowing difficulty in dementia show a high rate of dysphagia. Bronchopneumonia was the leading cause of death in Alzheimer's disease and 28.6% in this study were found to be aspirating. (Horner et al, 1994)

23% of older people referred to SLT Mental Health Services in Aberdeen have a mental health diagnosis (e.g. depression, anxiety) plus dysphagia. (SLT, Grampian).

A study of 60 people using both acute and community care services found 23% of people with schizophrenia and 27% of people with bi-polar disorder had a swallowing impairment. This is considered a gross underestimate as identification in this study relied on external observation. Objective assessment, for example using videoflouroscopy, would, it is expected, increase identified cases in this population. (reference tbc)

78% of patients with mental health disorders screened had communication impairments ranging from severe receptive and expressive dysphasa, dysfluency, hearing problems, voice and articulation problems and dysarthria (Emerson and Enderby 1998).

Incidence of speech and language problems in people receiving mental health services is substantially higher than the general population.(Bryan, Maxim and Macintosh et al 1991)

A consistent finding of studies on patients with mental illness is that they have poor communication skills, which persist even when the illness is pharamacologically controlled (Mueser et al., 1991; Trower, 1987; van Dam-Baggen and Kraaimaat, 1986).

ii) Legislation and Policy

There are numerous pieces of legislation and policies of relevance to this care group to which SLTs can and do make a very positive contribution.

- **Mental Health (Care and Treatment)(Scotland) Act 2003:**
  The principles in the Codes of Practice emphasise the need to take account of persons feelings and wishes using whatever means of communication best suits the person.

  SLTs are specifically qualified to and skilled in;
  - Assessing the communication capacity of an individual
  - Advising on and providing the best means by which to ascertain present wishes and feelings of the adult.
  - Defining the individual's needs in terms of aids and adaptations to optimise their communication capacity.
  - Providing advice, training, support and the necessary aids and adaptations to those living with, caring and working for the individual.
  - Directly assist those living with, caring and working for the individual to communicate effectively with the individual.
  - Advise on the most effective means of presenting information and choices to the individual thereby maximising the adults opportunity to exert free choice.

- Adults with Incapacity Act - revised Codes of Practice

Principles that form the foundation of these Cpdes of Practice are similar to those in Mental Health (Care and Treatment)(Scotland) Act. SLTs have a similar role to that described above in relation to Adults with Incapacity due to mental disorder. The role of SLTs is made more explicit In the revised Codes of Practice (Part V).

- **National Care Standards for Older People with Mental Health Problems living in Care Homes**

  Standard 18 - Supporting communication - states

  "...people should expect to "have help to use services, aids and equipment for communication, if (their) first language is not English or if (they) have any other communication needs."

  Meeting this standard involves regular assessment and review of individual's communication needs; staff helping individuals to get and use specialist communication equipment and support from named worker or trained communication support workers, including trained Interpreters.

  SLTs are central to
  - Assessment and review of person's communication needs;
  - Provision and effective use of specialist communication equipment;
  - Training support workers and others about how best to interpret, respond to and support a person's communication.

- CAMHS Framework
  Identifies SLTs as key members of tier 3 and 4 services.

- **Delivering for Health**

  Underlying strategies arising out of Delivering for Health are the common themes of

  self care, patient as partner and carers supported as partners.

  All these themes require effective communication between providers and service users. SLTs are uniquely placed to advise on achieving related objectives in relation to estimated 250,000 people in Scotland with communication support needs.

B: Speech and language therapy activity, value and impact in MH Services

The following sections (1-5) describe SLT activity and provide evidence of the value and impact of each of these activities in turn.

1. Detailed assessment of communication skills and needs

Involves
- Assessment of individuals verbal and non-verbal receptive and expressive language skills and factors that contribute to the person's communication competence across a range of environments.

- Assessment methods include both direct formal and informal assessment of the individual (e.g. detailed discourse analysis to identify indicators of for example psychotic illness) and consultation with the persons family members and significant others.

Value / Impact

- **Contributes to multi-disciplinary team (MDT) diagnosis**

  Language disorder is under-diagnosed in this population.

  Psychiatrists and neurologists have difficulty differentiating schizophrenic from dysphasic speech but SLT assessment is known to be more reliable. (Muir, Taimer and France 1991)

  Individuals with suspected dementia should have access to SLT assessment and management as part of a multidisciplinary team with specialist mental health skills (Heritage & Farrow, 1994).

  Language problems appear to be directly implicated in the onset and course of psychological disorders and may well be risk factors (Cantwell, Baker and Mattison, 1979).

- **Contributes to differential diagnosis**

  Language assessment contributes to differential diagnosis between different types of dementia (Snowden & Griffiths,2000) and make a vital contribution to early diagnosis (Garrard &Hodges, 1999).

- **Provides a model for intervention based on assessment findings**

  SLT can relate intervention to assessment findings, where otherwise intervention is largely pharmacological and activity-based (Muir, 2001).

- **Contributes to impact of MDT intervention**

  The majority of the MDT intervention is mediated through verbal and written communication. SLT assessment and subsequent advice and support can optimize the impact of others interventions.

  Team members get greater satisfaction from encounters if their own communication skills are maximised and therefore adequate to the task. Support for training from SLT's. (Erber 1994)

- **Contributes to individual's, carers and others understanding of factors contributing to mental illness.**

  Orr (2001) notes that the SLT enables the rest of the team by facilitating the team's understanding of the patient, allowing for risk assessment, diagnosis and therapy.

- **Provides baseline to monitor change and evaluate ongoing intervention**

Comprehension and language assessment can be a sensitive indicator of change in functioning following drug treatment.

2. Development and provision of communication programmes

Communication programmes developed by SLTs commonly have two distinct elements;

i) Direct one to one and / or group therapy.

Involves -

- Therapeutic interventions designed to remediate and / or facilitate communication in the areas that are difficult for the individual, e.g. turn taking, problem solving and negotiation through appropriate language and non-verbal behaviour, conversation skills and / or stimulating use of language and communication.

Value / Impact

- Helps the individual to achieve greater insight into their communication difficulties (where appropriate) which in turn to reduce frustration caused by communication impairment and improves confidence.

- Enabling the individual to develop new or regain "lost" communication skills, motivation and confidence.

  Hoffman and Satel (1993) reported good results with direct therapy to improve language and reduce auditory hallucinations.

  Social skills training found to be effective with patients with schizophrenia. (Mojabai et al)

- Enabling the individual to maintain current communication skills or help them to make optimum use of residual skills.

  Increased use of language may enable patients to maintain communication skills for longer or may have an impact on mood, confidence and general well-being. (Clark L 1995)

  Social skills training may help the illness to stabilise. (Hartley 1993)

- Enabling the individual to gain from others MDT interventions which are mediated through language

  Dobson et al. (1995) noted a reduction in medication dosage with therapy for communication skills. (also noted in a single case study by Clarke, 1997)

- Contributing to individual's mental health

  Work on communication can contribute to an individual's mental health.. See Dobson et al. (1995) above.

  "Successful communication is also essential in enhancing the well-being of the individual." Shulman MD & Mandel E (1988)

ii) Indirect Therapy

Involves

- Assessment of the individual or client groups "communication environment" in relation to attitude, knowledge and skills of those they live, learn, work and socialize with as well as the physical environment, resources, structures and systems in place to support optimum communication by and with the individual.

- Provision of training and / or user friendly advice and guidelines to carers and others describing appropriate strategies to enhance the individuals (or a particular client groups) communication.

- Provision of appropriate resources such as communication aids to facilitate implementation of recommended communication strategies. For example "translating" written legal information and forms in to communication accessible formats for people with a diverse range of communication support needs.

Value / Impact

- Contributes to creation of an environment conducive to mental health and well being of the individual by reducing individual's and others "interaction related" distress.

  Social skills training improves relationships of schizophrenic patients with their families.(Leff 1994)

- Supporting service users to access mainstream community services more generally e.g. local leisure facilities.

- Reduces incidence of challenging behaviours arising out of communication breakdown between individuals and those around them.

  inability to communicate effectively may be the cause of many challenging behaviours (Bryan & Maxim, 2003; Stokes, 2004).

  Orr (2001) refers to a number of individual cases, where in each case SLT resulted in improved communication so that frustrations were no longer commuhicated via aberrant behaviour

- Increases potential for successful interaction between **MDT** colleagues and patients with various mental illnesses and thereby improving the impact of interventions across the **MDT**.

  For personality disorder management conversational analysis resulted in communication changes by both psychiatrist and personality disordered patient, allowing subsequent therapy where patient had been considered untreatable. (Kramer, 1999)

  "The pre-condition for successful participation in most forms of psychotherapy is adequate communication skills" (France 1995).

"Successful communication is also essential in enhancing the well-being of the individual." Shulman MD & Mandel E (1988)

Orr (2001) notes that the SLT enables the rest of the team by facilitating the team's understanding of the patient, allowing for risk assessment, diagnosis and therapy.

Team members get greater satisfaction from encounters if their own communication skills are maximised and therefore adequate to the task. (Erber 1994)

- Supports MDT to fulfill legal obligations for example under the Mental Health Act and Adults with Incapacity Act. Codes of practice emphasise requirement to optimize individuals involvement in decision making and care planning using communicatipn supports appropriate to the individual. SLS are uniquely qualified to assess need and advise on appropriate communication strategies.

- Helps carers cope with stress associated with interaction with individuals.

There is evidence that carers find behavioural and communication problems more stressful than aspects of Activities of Daily Living (ADL) and self care impairments (Haley et al, 1994).

- Increases MDT and others awareness of communication in general and the impact their communication behaviour has on the mood, motivation and behaviour of service users.

Faber, Abrams and Taylor (1983) and Fraser et al. (1997) report on the value of SLT descriptions of language in schizophrenia due to their specialist training.

Thomas (1997) states '...at present, theoretical linguistics, and practical assessments of human communication based on this, plays no part in the education and training of psychiatrists. Speech and language therapists have an important role to play in the future education of psychiatrists'.

3. Assessment of eating, drinking and swallowing difficulties.

Involves –

- Observation, formal assessment, discussions with carers and others and often videoflouroscopic examination. Also includes consideration of effects of mental health and mood, posture and general social skills, medication and the environment on eating, drinking and swallowing.

Value / Impact

- Contributing to MDT diagnosis and effective management planning.

Eating and swallowing problems are common within this client group due to the side effects of medication. Differential diagnosis of the nature of the problem, eg, iatrogenic (due to drug therapy) versus psychological, is essential for effective management. Bach DB, Pouget S, Belle K, Kilfoil M, Affieri M, McEvoy J & Jackson G (1989)

- **Contributing to the MDT decision regarding need or non-oral nutrition and hydration.**

4. Development and provision of eating, drinking and swallowing programmes.

Involves -

- Production of eating, drinking and swallowing guidelines often in collaboration with other members of the dysphagia team – physiotherapists, dietitian, occupational therapists, nursing staff in hospitals and care homes and, if vidoeflouroscopy involved, consultant radiologist and radiographer.

- Provision of training and demonstration for those preparing food and giving the person food and drink, including family and carers, wherever the person consumes food and drink.

- Ongoing monitoring and evaluation of the eating and drinking programme, altering aspects as person functioning improves or deteriorates.

Value / Impact

- **Establishing safe and effective eating, drinking and swallowing ensures adequate nutrition, reduces risk of infection and illness and contributes to general physical and mental well being of individuals.**

Identifying which behavioural strategies facilitate the eating and drinking process and communicating these to the relevant carers maximises the effectiveness of the individual's eating and drinking. (This) may also have a positive impact on both the individual's and carer's psychosocial experience of mealtimes. Coyne ML & Hoskins L (1997), Kayser-Jones J & Schell E (1997), Osborn CL & Marshall MJ (1993).

5. Take on wider roles with the mental health team either individually or as co-workers.

C: SLT mental health services in Scotland.

According to a 2005 RCSLT survey of SLT services there are only an estimated 13.1 wte SLT posts dedicated to all mental health care groups in Scotland including Child and Adolescent Mental Health (CAMHs), old age psychiatry, learning disability with co-morbid mental illness and forensic - learning disability services. This compares to 11 wte in Rampton Forensic Unit (England) alone.

1. **Of the ten health boards which responded to the RCSLT survey only 6 had any dedicated service at all. There are very few if any SLT sessions provided in general psychiatry services across Scotland.**

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