What do we mean by Communication Support Needs (CSN)?

- **Having difficulty understanding normal speech or writing** – so a person might not be easily able to read a poster, leaflet, appointment card, letter, magazine or sign outside a building; interpret ambiguous or sophisticated adverts; access or read websites; understand advice on the phone or join in groups with lots of “talk” based activities and/or
- **Having difficulty expressing self effectively using normal speech and/or writing** – so a person might not easily be able to name, describe or speak about their thoughts and feelings; problem solve or negotiate using speech or writing; use a telephone help line; use an on-line support service; confidently use a face to face advice service or engage in group work.

Who has Communication Support Needs (CSN)?

1. Mental Health and Well Being Programmes target groups.
   a) Boys and young men
      - Boys account for 3 out of 4 children with speech and language impairments.
      - Polmont YOI - 26% of young men in have clinically significant communication impairment and 70% of young offenders have problems with poor literacy and numeracy (SPS own figures).
   b) Children
      - 5% of child population have significant communication disorders.
   c) Children, young people and adults from disadvantaged communities
      - Higher incidence of difficulties reading or reading English among communities with poor life circumstances, BEM communities, travelling people.
      - Higher incidence of illness affecting communication e.g. Stroke
      - Sure Start Objectives recognise essential need to focus on development of children’s and parent’s skills in communication and language.
   d) Older people
      - High incidence of conditions or disability affecting communication, e.g. sensory impairment, literacy difficulties, aphasia, dementia and Alzheimer’s, MND, MS, cancer (CNS, Head and Neck).

2. Majority of people who end up in psychiatric services.
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- Of 62 attendees at area psychiatric services (acute to community based) 84% had a language impairment and 74% had communication and discourse problems. RCP (2004).
- 78% of patients with mental health disorders screened had communication impairments ranging from severe receptive and expressive dysphasia, dysfluency, hearing problems, voice and articulation problems and dysarthria (Emerson and Enderby 1998).
- 62% of children in psychiatric populations had speech and language impairment. 28% had previously been identified with 34% previously undetected. (Goodyer, 2000; Cohen 1993)

3. Anyone who is ill, tired, anxious, angry, frightened etc.

What’s the link?
1. Certain groups within population populations have high levels of CSN including number of the target groups of the national programme therefore health promotion and prevention has to take account of CSN – for equal access sake.

2. There appears to be a correlation between CSN and psychiatric service use therefore it would make sense for health promotion, prevention and rehabilitation programmes to be targeted at or at least made accessible to people with CSN.

How can MHWB programme implementation respond to this link?
Develop and implement an “Inclusive Communication Strategy” and then apply to all promotion, prevention and rehabilitation programmes.

In practice this could mean
1. Developing a good “Service to User” Communication Standard to encompass the needs of everyone with or without CSN then
2. Implementing the good “Service to User” Communication Standard through the provision of guidance and skills training for front line staff and the development of appropriate communication support resources. E.g. symbol based leaflets, posters, letters etc; guidance on how to simplify language to reach maximum audience etc.

What can Speech and Language Therapists do?
- Advise on development and implementation of an Inclusive Communication Strategy as part of the MHWB Programme implementation.
- Advise on how to make health promotion, prevention and rehabilitation programmes more inclusive of people with CSN,
- Support MHWB work force to develop appropriate communication skills and competences and
- Support development of practical communication resources to make programmes more accessible to people with CSN.
Facilitate partnership working with a variety of user organisations representing people with CSN.

Kim Hartley
RCSLT Scotland Officer
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)

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).

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 videofluoroscopy, 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 dysphasia, 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 Codes 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.

- **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 communicated 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 communication supports appropriate to the individual. SLS are uniquely qualified to assess need and advise on appropriate communication strategies.
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- **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, Alfieri 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,
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occupational therapists, nursing staff in hospitals and care homes and, if videofluoroscopy 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.

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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