Resource Manual for Commissioning and Planning Services for SLCN

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Acknowledgements

The RCSLT and the Project Team would like to thank all those who assisted in drafting this guidance. We have received valuable advice from many reviewers from within the speech and language therapy profession who have given up their time generously. Experts on particular topic areas from related professions have also been consulted and assisted with detail. Service Commissioners and senior managers have commented on drafts showing patience and fortitude!

We would particularly like to thank the many who contributed to the focus groups which helped to shape this document.
CONTEXT

The aim of this section is to set out the context for this resource. This work forms part of a range of tools which can support leaders with service planning and delivery, in line with both government and local priorities.

It is essential for service providers to demonstrate quality and productivity and to:
- show value for money
- be able to provide a strong financial argument for the need to invest in services for people with speech, language, communication and swallowing needs
- demonstrate improvements in outcomes for individuals, families and society

Value for money is not about being the cheapest option but about delivering the most return (impact, best outcomes) for a given investment over time.

The key drivers for change to services include:

1. The broad context, which can be divided according to the following factors:
   - Political and Legislative factors
   - Economic factors
   - Social factors
   - Technological factors

2. The near or local context, including:
   - Localised policies
   - Addressing local needs
   - Service provision
   - Workforce
   - The evidence base

THE BROAD CONTEXT (MACRO-ENVIRONMENTAL ANALYSIS): FACTORS FROM THE WIDER WORLD

The Macro-environmental analysis commonly takes the form of a PEST analysis:

Political and legislative factors
Economic factors
Social factors
Technological factors

Political and legislative drivers

Devolution has resulted in changes to the powers of the different institutions across the UK.

The government in power at Westminster maintains responsibility for policy and legislation in relation to key areas including: tax, benefits, foreign affairs, international development,
trade and defence for the four countries of the UK. Government in Westminster is also responsible for health, social care and education in England, but these areas are devolved for Northern Ireland, Scotland and Wales.

As a result of devolution, each country of the UK may have different parties in power, with the possibility of increasing powers in the future. The impact of this is the diversification of policy and direction of travel.

**Legislative drivers**

The main areas of UK-wide legislation that are relevant include the following themes:
- Human Rights
- Disability Discrimination
- Equality

Though there is different local interpretation, these far-reaching legal instruments define the rights and responsibilities of people and those commissioning and providing services for them.

Public protection has also been strengthened through the introduction of registration of professionals, for example, through the Health Professions Council.

There is separate legislation relating to health, education and social services in each of the devolved administrations in England, Northern Ireland, Scotland and Wales.

**Economic**

The current challenging economic backdrop will have a significant impact on the financing of public services, with local planners and commissioners prioritising services which are value for money, evidence based and releasing cash through innovation.

**Social**

In order to plan and deliver services, it is essential to identify the demographic factors relevant to speech and language therapy (SLT) and the challenges that these bring.

- The population is aging: people are living longer.
- The birth rate is falling: most families are having fewer children
- The infant mortality rate is also falling, with more children surviving premature birth or health problems or injury in infancy.
- The urban population is growing.
- The proportion of the population in employment is falling.
- The proportion of the population with English as an additional language is increasing, particularly in urban areas.
THE NEAR OR LOCAL CONTEXT

Localised policies

Central to the new reforms is the emphasis on local decision-making within a national framework. Across the four countries of the UK there are requirements to provide services to accord with local need and influence. In England there is a particular focus on increasing the range of potential providers (plurality of provision) with commissioners having a role to stimulate the market.

For each country, arrangements have been established to assess whether commissioners are achieving better health outcomes for the local population. Part of this process will be an assessment of how well commissioners are performing against specified competencies/indicators/targets. For example, in Northern Ireland these targets are based upon high-level outcomes linked to local strategies.

With the devolution of power to local levels, there is a focus on developing more robust accountability. There is an emphasis on joint working to support integrated commissioning, service planning and provision across health, social care and education.

There are different approaches to this development with different structures and commissioning and performance management arrangements being established across the UK. The dominant theme in strengthening accountability is “putting service users at the centre” with respect to:

- Access and self-referral
- User voice at strategic to operational to individual case management
- Population/local engagement
- Information and advice for users, parents/carers
- Patient Rights
- Self management of conditions

Some localities will be commissioning or planning speech and language therapy services as a single service whilst others will be commissioning integrated services, cutting across traditional boundaries, with health services integrated with education or social services. In many areas, this has already happened for children’s services.

It is recognised that, often, no single agency can deliver best outcomes for their service users by working in isolation. Joint commissioning is advocated wherever the meeting the needs of individuals requires contributions from a number of agencies.

Similarly, some service planners or commissioners will be organising services around disease groups, such as services for persons who have survived a stroke. In either case, it will be important for speech and language therapy managers to liaise with other services to ensure that SLT provision is incorporated in their service plans.

Special arrangements are in place for commissioning services for unusual, low incidence or costly interventions. Speech and language therapy managers should identify the specialist commissioning procedures that may be required for individuals requiring
particular interventions such as costly augmentative communication aids, protracted or intensive interventions.

Addressing local needs

In general terms, the UK is experiencing a number of long-term demographic changes (some of which are identified above).

There is significant local variation within these general trends. It is important to understand what these changes and variations imply in relation to the provision of local SLT services. Other local factors to be taken into consideration include: employment, cost of living, housing, transport and, particularly, levels of deprivation.

There are information resources available online from which planners, commissioners and providers can find out more about local and regional demographic factors. Some of these can be found signposted on the RCSLT website [www.rcslt.org](http://www.rcslt.org).

Local public health teams will also be able to sign-post local services to relevant data and information for their area.

There will also be learning from data collected by services. The RCSLT has developed an online tool called Q-SET, the Quality Self-Evaluation Tool to help you collate local SLT service derived information [http://www.rcslt.org/resources/qset](http://www.rcslt.org/resources/qset). Q-SET should be used alongside national and local data to support service planning and evaluation of service delivery.

Through completing Q-SET, provider services can:
- use the resource every 9-12 months to review progress in meeting action plans and to demonstrate service enhancement
- compare their service with other similar service types e.g. urban, rural, acute, community, adult, paediatric, education, 3rd sector
- demonstrate that their service meets the needs of the service users
- identify areas of strength and generate action plans relating to areas of development.
- submit the results as part of the evidence for a clinical audit
- retain ownership of the monitoring and development of services ensuring that strong professional standards are maintained in the context of multi-agency teams

Service providers completing Q-SET will support commissioners to:
- reduce the ‘postcode lottery’ of service availability and quality
- have high quality information that is relevant and accessible
- have an overview of developments, trends and initiatives within the service
- have accurate and timely statistics to support performance management and monitoring
- collect data to contribute to the debates on benchmarking. Where benchmarks do not yet exist Q-SET will enable Commissioners to contribute to this in the future
- collect examples of good practice to inform other pieces of work and the development of services as a whole.
Locally derived information will help SLT services to illustrate:
- the numbers of patients/clients seen
- sources of referral
- amount of resource used in providing a service to the client e.g. number of sessions and skill mix
- nature and severity of the disorder, disability, psychosocial impact at the onset of intervention
- nature and severity of the disorder, disability, psychosocial impact at the completion of intervention.
- level of satisfaction with the service.

Service provision

Speech and language therapists have a role in delivering specialist and targeted support to clients, carers and their families. Speech and language therapists can also reduce long-term demands on services by addressing immediate needs that arise from circumstance rather than underlying impairment. Providing training for the wider workforce is integral to the speech and language therapists core role, as outcomes for people with speech, language and communication needs SLCN are improved when the whole workforce is able to contribute appropriately to care pathways.

SLTs also work with the wider workforce contributing to the public health agenda, promoting health and well-being in respect of communication and swallowing. There is little awareness outside the profession of the role of speech and language therapists in preventing the development of speech and language impairments and the further impact and consequences of different speech, language and communication disorders upon health, education, social integration and employment.

The challenges of meeting the speech, language and communication needs (SLCN) of a given population are best understood through a social (participative) model. Key elements of a total service specification will start with:
- identifying the needs of the service user, parent or carer for support and information
- identifying/assessing and diagnosing specific SLCN and providing appropriate intervention.
- considering needs of service users within the environments they encounter
- training the wider workforce that interfaces with them to maximise opportunities for positive outcomes.

The balanced system (diagram 1) below illustrates the wider context for how SLTs contribute to this range of activities. The needs of service users should be considered in service specifications. The role of SLTs in supporting the active participation of service users in service planning, adapting the environment and enskilling the workforce is as relevant as the SLT role in identification and intervention.
Workforce

Careful planning of services, including joint commissioning, will help to shape the workforce and inform the skill mix required to deliver high quality services, improve outcomes and support value for money. Because the commissioning and planning of services relies on the evidence base for a given type of SLCN or model of practice, it is essential that clinical and managerial expertise from speech and language therapists is available to support innovation and quality of service design.

Speech and Language Therapists, as part of the wider workforce, may be employed by a range of organisations, including the third sector, social care and education or be working as private practitioners.

Equal Access to services is of importance to local decision makers. Local demographic profiling will inform workforce requirements. For example, bilingual staff and support workers are required in most areas to meet the needs of diverse communities. The appropriate skill mix should enable services to be family-centred and be culturally and linguistically appropriate and responsive. It may be necessary to consider increasing home delivered services or providing services in unusual locations.

The RCSLT also acknowledges the important role that Assistants and Support Workers have in the delivery of effective speech and language therapy services. Assistants and Support Workers are integral members of both speech and language therapy and multi-disciplinary teams, engaged in a wide range of clinical settings with diverse client groups, duties and responsibilities. [http://www.rcslt.org/aboutslts/rcslt_statement_v3.pdf](http://www.rcslt.org/aboutslts/rcslt_statement_v3.pdf)
In order to support more effective use of skill mix, SLT services also need to provide education and training of the wider workforce and not be focussed solely on direct patient / client care. For all services, this is critical to secure the appropriate balance of cost-effective universal, targeted and specialist services.

PRACTICAL CONSIDERATIONS

Many people involved in strategic planning, commissioning or reviewing services will not be familiar with speech and language therapy, its objectives, the needs of clients requiring speech and language therapy, the principles driving the profession, or the evidence base and the following points may support people.

- Where possible, draw on the evidence base.
- Communicate clearly and succinctly.
- Avoid using acronyms and provide a glossary of terms.
- Do not assume knowledge of local arrangements or the requirement to interface with other agencies
- Set your service in the context of local priorities.

The RCSLT’s Communicating Quality 3 (CQ3) provides clear guidance on care pathways, clinical standards and issues related to quality assurance. This information should be used in submissions to support commissioning quality services.

The following guiding principles have been adopted and apply to all client groups. Services are to:

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be family centred and culturally and linguistically appropriate and responsive
be comprehensive, coordinated and team based
work with and communicate effectively with other services meeting the needs of the client
be evidence based
ensure equal access
involve the family and carers
include training and education of co-workers
ensure practitioners continuing professional development and appropriate support.

evidence of the impact of the service will be important to commissioners and providers. Providers will need to demonstrate the impact of their service, particularly when services are being reviewed. Determining the objectives of the service will support the process of outcome measurement. SLT services will need to provide information on outcomes achieved and levels of client satisfaction. Some of this information can be gathered through use of the RCSLT’s Q-SET tool, as detailed above.

Managers of speech and language therapy services will need to equip themselves to engage effectively and positively with those who are commissioning or monitoring services. They will need to:

- identify who is commissioning or responsible for overseeing different services. For example, health commissioners may be working with commissioners for education/head teachers. It is important to identify who is taking the lead for each aspect of the service delivery in the locality.
- establish good working relationships and effective communication with those commissioners and planners for their area of responsibility.
- be aware of local priorities and commissioning plans and strategies.
- have a good understanding of the commissioning/planning/monitoring framework for the locality
- be equipped with local data, knowledge and evidence to the tendering process
- be clear of the unique contribution of the service to improving health, employment, education and social outcomes
- be able to clarify and demonstrate local working partnerships and collaborations
- provide data describing the service provided, (numbers and types of patients, numbers of attendances, health and social outcomes etc).

The RCSLT has developed a range of resources to support its members with Continuing Professional Development. CPD is a regulatory requirement for all SLTs and this requires all HPC Registrants to demonstrate how the CPD they have undertaken has sought to enhance service delivery and to be of benefit to service users. The RCSLT has endorsed this requirement through its own CPD standards. http://www.rcslt.org/cpd/resources
THE EVIDENCE BASE

The commissioning and planning of services must be informed by the evidence base of effective practices.

This Resource Manual SLCN is based on a synthesis of existing published research. The threshold for inclusion in the syntheses has favoured the most scientifically robust research methodologies which have often reflected medical (impairment) rather than social (participative) models of care.

In the section summaries, emerging practices that have not been included in the evidence synthesis, are referred to and should be considered alongside the syntheses. This tension between empirical evidence resulting from robust research, which by definition is retrospective, and the needs to encourage innovation and service re-design to support improvements in outcomes for people with speech, language, communication and swallowing difficulties is natural and unavoidable. Emerging practice will not have the same evidence base and therefore less empirically stringent measures of evidence need to be taken into account for these areas including professional consensus and measures of service user, parent or carer experience. However, because of the value of some emerging innovative practice, they have been included in this resource.

An overview of the methodologies employed in identifying practices that are included in this resource accompanies this document.

Using these resources

Speech and language therapy managers can assist commissioners by understanding their agenda and the objectives that they are to be assessed on.

The Royal College of Speech and Language Therapists is providing these resources to assist speech and language therapists in gathering the core data required to support service tendering agreements, service planning, monitoring arrangements and/or where services require specification.

Each part of these resources is focused on a specific area.

The resources provide:

- **The Contextual Synthesis.** This includes definitions, information on the incidence and prevalence of the disorder, key contribution of speech and language therapists, consideration of the implications and broader consequences of the disorder.
- **The Synthesis of Key Literature.** This summarises the evidence of the impact of speech and language therapy.

Each section within these resources gives succinct information to inform the factual content for any service planning activity. These include:

- Key points
- Topic –What is [the condition]?
- How many people have [the condition]?
What causes [the condition]?
How does this condition affect individuals?
What are the aims/objectives of speech and language therapy interventions for [this condition]?
What is the management for people with [this condition]?
What is the evidence for speech and language therapy interventions in [this condition]?
Studies
Assessment methods
Speech and language therapy interventions
Summary
References

This information will need to be put into context, using local information.

Other guidance and resource materials

It is recognised that service managers may wish to amplify or clarify, an aspect of their service by providing reference to other national or local research of relevance.

The RCSLT has a range of resources which can be used to further support and inform the commissioning, planning and provision of services for people with speech, language, communication and swallowing needs. These can be found on the RCSLT website: www.rcslt.org

The RCSLT is grateful to the experts from within the SLT community who contributed to the evidence published in this document.
METHODOLOGY FOR SYNTHESIS OF LITERATURE

Introduction

The focus of the interventional synthesis within these briefings is to provide a synopsis on the effectiveness of speech and language therapy interventions for each specific condition.

The interventional syntheses are produced by reviewers within the Information Resources Section (within the Health Economic and Decision Science Section) at the School of Health and Related Research (ScHARR). Information specialists/reviewers for this bulletin were Diana Papaioannou and Anna Cantrell.

Methodology

The interventional syntheses are not intended to be a full systematic review within each topic area. However, they draw upon systematic review techniques to ensure that the syntheses are developed according to systematic, explicit and transparent methods. The intention of the syntheses is to consolidate twenty articles which represent some of the best research for each topic area.

Literature searching

Systematic literature searches were undertaken to identify a range of evidence for each interventional synthesis. The interventional syntheses do not attempt to consolidate all research within a particular topic area; rather they aim to present a careful selection of the most current research within that field. Therefore, the approach adopted for the literature search aims to be comprehensive reflecting this systematic and explicit approach.

Firstly, search terms were selected within the project team drawing on the expertise of four speech language professionals. This involved listing all possible synonyms describing the condition or population (for e.g. children/infant, stuttering/stammering) and combining those with terms to describe speech and language therapy. Terms were used in both free text and thesaurus searching. The following databases were used:

- ASSIA
- CINAHL
- The Cochrane Library (which includes the Cochrane Database of Systematic Reviews, Cochrane Central Register of Controlled trials, Database of Abstracts of Reviews of Effects, Health Technology Assessment Database and NHS Economic Evaluations Database).
- Linguistics and Language Behaviour Abstracts
- MEDLINE
- PsycInfo

All references retrieved from the literature searches were entered onto a Reference Manager Version 11 database using appropriate keywords.
Selecting and obtaining relevant articles

Articles for inclusion were selected to illustrate the range of good quality evidence within each topic area. An initial screening of articles was undertaken by the Information specialists/reviewers who adopted the following principles:

- Articles must be empirical research evaluating the effectiveness of a particular speech and language therapy intervention
- Only articles published in English language are included.
- In general, only the most current (1998-present) literature is included. However, exceptions were made to this if a particular article was felt to be important to include.
- Where possible higher level evidence was included (systematic reviews, randomised controlled trials). However, this research did not always exist in every topic area.
- Efforts were also made to seek out literature that provided a range of perspectives on interventions for each topic area, i.e. both quantitative and qualitative research.

Following initial screening, the remaining articles were examined by two members of the team; each having considerable speech and language therapy knowledge and experience. Approximately, twenty articles were selected by the two reviewers with disagreements being resolved by a third reviewer.

Assessing the quality of relevant articles

Formal quality assessment of the articles was not undertaken. Instead, quality assessment involved using checklists as a guide to give an indication of the overall quality of studies and highlight the main good and bad aspects of each study. For each interventional synthesis, the included study designs are listed and the problems with each study design noted. General observations on study quality are made and common errors within the studies, where appropriate, are specifically noted. The checklists used are one for quantitative and one for qualitative studies from the Alberta Heritage Foundation for Medical Research.1 Additionally, when an identifiable study design was used, the appropriate Critical Appraisal Skills Programme (CASP) checklist was selected.2

Syntheses of the twenty articles

Each article was read in turn by one of the Information Specialists/reviewers. The key points were summarised including the objective of the study, the participants’ characteristics, the methodology, the intervention, results and limitations. From this, articles were grouped into themes according to the factor being investigated (for e.g., length of intervention, personnel carrying out intervention, family involvement in treatment, nature of disorder). Results were summarised and drawn together within each particular theme and a summary paragraph provided at the end.

These syntheses first went out for review by selected individuals, identified by the research team, with particular expertise in the delivery or management of services to the

specific client group. Comments were included in the second draft, which was then dispatched to those selected by the Royal College Speech and Language Therapists who were invited to attend a focus group day. These therapists gave detailed consideration to their specialist area and contributed to the more general discussion of one further area. Issues to be captured in the key points were also identified within the focus groups. These comments contributed to the third draft of the syntheses, which again went out to reviewers. In some cases, further work was required in order to modify the wording and reflect discussion.

**Checklist for service managers involved in commissioning services**

- Have you presented incidence and prevalence figures and local demographic trends for the conditions in your area?
- Have you provided information on local access and use of services in the context of the number expected and highlighted your approaches to inequalities?
- Have you consulted systematically with users to inform development of this commissioning proposal?
- Does your proposal fit/link with local cross agency priorities?
- Have you outlined the range of services provided including training?
- Have you made clear how this fits with future planning for your service over the next 3-5 years?
- Have you stated the assumptions which underpin your thinking in the plan and for future developments?
- Have you offered predictions about the likely impact of investment in the proposal?
- Have you made clear where the risks are and what contingency plans you have put in place?

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RCSLT RESOURCE
MANUAL FOR
COMMISSIONING AND
PLANNING SERVICES FOR
SLCN

Mental Health
Mental Health

The Syntheses within this RCSLT series on Voice, Aphasia, Autism, Speech and Language, Fluency, Dysphagia, Dementia, Dysarthria and Cleft Palate and Velopharyngeal Abnormalities, and Learning Disabilities have reported on Mental Health issues specific to those communication disorders. This particular section addresses mental health issues associated with speech language and swallowing/eating disorders.

1. Key Points

1. A high proportion of children and adults presenting to mental health services may have disturbances of speech, language, communication and swallowing which may be difficult to identify.

2. Speech, language and communication disorders may be intrinsic to the mental health problem, may pre-date the mental health problem or may arise from it.

3. Difficulties with social communication result in reduced access to education, recreation, employment, social integration including forming relationships and expressing personality.

4. Improved communication has an impact on behaviour, social skills, peer relationships and self-confidence.

5. Speech and language therapists have a unique role in identifying the communication characteristics and swallowing disorders, contributing to differential diagnosis and facilitating identification of retained abilities and comorbidities e.g. motor speech and swallowing impairments.

6. A Speech and Language therapist should be an integral member of multidisciplinary health and social care teams supporting clients with mental health problems, contributing to the assessment, diagnosis and care plan.

7. Speech and language therapists help to enable individuals to integrate socially and participate in life roles (education, work, social) and to access and benefit from verbally mediated interventions.

8. Speech and Language Therapists can manage underlying speech, language difficulties associated with the increased prevalence of challenging behaviours.

9. Speech and Language Therapists contribute to maintaining children in families and schools and through improved communication has an impact on literacy, numeracy and skills for learning.

10. There is evidence that training provided by speech and language therapists having a positive impact on the behaviour of others in promoting communication with persons with mental ill health.

11. Persons with mental ill health and associated communication difficulty are at risk as defined by the Incapacity Act and speech and language therapists are integral to assessing competence for consenting.

12. The Speech and Language Therapist has a key role in assisting individuals with communication problems to make informed decisions when balancing the risks and benefits of treatment options.

13. Speech and Language Therapists ensure that aspects of the care pathway are accessible to the individual, taking account of their multiple needs and the changing focus of intervention at different points in their care.

14. Specific SLT interventions with those with a primary speech, language, communication or swallowing disorder may prevent secondary mental health problems.
2. What is Mental Health?

Mental Health refers to a state of social, physical and mental well-being which can be affected by biological, individual and social influences and perspectives (WHO ICF 2001) (RCSLT Position Paper 2009, WHO Mental and Behavioural Disorders 2001). Disorders of mental ill health may be transitory, enduring or recurring and cause personal distress or impaired functioning in one or more areas an individual's life. Mental Health (MH) Disorders can manifest themselves as overt or covert symptoms relating to anxiety, depression, personality, attachment, addiction, and cognitive disorders.

International Classification of Diseases – 10: Classification of Mental and Behavioural Disorders (WHO 2001) has classified Mental Health Disorders under ten groups, specifically:

- F0-9: Organic, including symptomatic, mental disorders (e.g. dementia)
- F10-19: Mental and behavioural disorders due to use of psychoactive substances
- F20-29: Schizophrenia, schizotypal and delusional disorders
- F30-39: Mood [affective] disorders (e.g. bipolar, depression)
- F40-48: Neurotic, stress-related and somatoform disorders (e.g. phobias, anxiety, depression)
- F50-59: Behavioural syndromes associated with physiological disturbances and physical factors (e.g. eating disorders)
- F60-69: Disorders of personality and behaviour in adult persons
- F70-79: Mental retardation
- F80-89: Disorders of psychological development (e.g. autism)
- F90-98: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (e.g. selective mutism, hyperactivity, conduct and emotional disorders)
- F99: Unspecified mental disorders.

Specific MH conditions can have communication and eating/swallowing difficulties associated with them, for example, mood, schizophrenia, dementia, psychosis while specific communication difficulties can affect mental health, for example, dysphasia, dyspraxia, dysphagia, autism, learning difficulties, attention deficit disorders and specific speech, language and communication needs.

Those persons with a primary communication impairment are at greater risk of a secondary mental health disorder, commonly anxiety or depression (Snowling et al 2006). It is recognised that there is an inter-relationship between communication and swallowing disorders and emotional, behavioural or psychiatric disorders (Beitchman 2006, France & Kramer 2008, National Schizophrenia Centre 2008).

There are individuals who experience MH problems related to pre-existing communication/ eating/ swallowing conditions and there are those individual whose communication/ eating/ swallowing difficulties are intrinsic to their MH condition. Dysphagia has a high associated co-morbidity with mental health problems (Stavrakaki 1999, Walsh et al., 2007, Bazemore et al 1991, Hussar & Bragg 1969, Regan et al 2006).

There are those who have MH problems that are present in childhood which may resolve, those MH problems that are life-long, and those MH problems that are acquired as adults.

It is established that there can be a relationship between speech and language communication difficulties and emotional and behavioural difficulties (Law and Plunkett 2009).
3. How many people have mental health disorders?

The World Health Organisation (WHO ICD-10 2002) reports the burden of Mental and Behavioural Disorders as being 25% of all people ‘at some time during their lives’, 10% of the adult population experiencing a Mental Health problem at any one time and some 20% of individuals seeing their doctor for more than one Mental Health problem. Kessler et al (1994) reported that 79% of people with a mental illness had a co-morbid condition; also that comorbidity occurred more frequently among women than men.

There is a high incidence and prevalence of speech, language and swallowing problems associated with MH in both children and adults (Bryan & Roach 2001, Brenner et al 2002, Beitchman 2006, Speech Pathology Australia 2008, Bazemore et al 1991, Hussar & Bragg 1969). The National Service Framework (NSF CAMHS 2004) reported that some 10-15% of all children have a diagnosable mental health problem. In the United Kingdom (UK) this equates to 1.1 million children, of which, 45,000 have a severe disorder. Cantwell and Baker (1991) found in their cohort that children with a MH problem had significantly more speech and language disorders than children without a MH problem. They cited 50-60% of children with a speech, language and communication disorder would fulfil the criteria for a mental health difficulty (Cantwell and Baker 1991). There is a higher incidence of mental health problems in those children looked after by the local authority in the UK, where the incidence of MH problems is 5 times higher for those children in Care. Meltzer et al 2002 reported that amongst 5–17 year olds in care, 45% had a mental disorder; 37% clinically significant conduct disorders; 12% emotional disorders; 7% hyperactive and 4% had pervasive developmental disorders, tics and eating disorders. Depression was more prevalent among girls with hyperkinetic disorders more prevalent among boys. In the UK, 1/6 adults experience some form of Mental Health problem, with approximately 16 % of the adult population experiencing depression or anxiety (Hosman & Jané-Llopis 1999).

Table 1: Incidence and prevalence figures for MH and MH in specific conditions

<table>
<thead>
<tr>
<th>Incidence</th>
<th>Prevalence</th>
<th>Country</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>10-15% of all children have a diagnosable mental health problem (NSF CAMHS 2004).</td>
<td>UK</td>
<td>Female to Male 2.6:1 to 1.5:1 (Garcia, Freeman, Francis, Miller, &amp; Leonard, 2004)</td>
</tr>
<tr>
<td>LD Mental Health problems 3 to 4 times higher if significant Learning Disability present (NSF CAMHS 2004)</td>
<td>Approximately 40% of individuals with a Learning Disability have a co-morbid Mental Illness. (RCSLT position paper 2009). Global mental illness across all intellectual disability levels, sex, and age ranged 16% - 54%, psychopathology in children 4.8-4.5 times higher than other developmental groups. Maladaptive behaviour 0.1-23% with aggression 6-32%, self-injury 4-21%, destructive behaviour 2-19% (Rojahn &amp; Meier 2009).</td>
<td>UK</td>
<td>Females &lt; maladaptive behaviour than males &gt; aggressive and destructive behaviour (Rojahn &amp; Meier 2009)</td>
</tr>
<tr>
<td>SLCN</td>
<td>84% attendees at area psychiatric services had a language impairment and 74% had communication and discourse affected (Royal College Psychiatrists 2004).</td>
<td>UK</td>
<td>20% females: 14% males aged 16-65 have significant mental health problems (Office for National Statistics 2009)</td>
</tr>
<tr>
<td>Incidence</td>
<td>Prevalence</td>
<td>Country</td>
<td>Gender</td>
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<tr>
<td>SLCN</td>
<td>34% of children attending psychiatric outpatient clinics had undiagnosed Specific Language Impairment (Cohen et al 1993).</td>
<td>UK</td>
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<tr>
<td>ADHD EBD</td>
<td>In a school for behaviour disorders there was a 42% under identification of speech &amp; language impairment and there was an overall prevalence of 74% in boys with ADHD or EBD (Stringer &amp; Lozano 2008).</td>
<td>UK</td>
<td></td>
</tr>
<tr>
<td>Emotional &amp; Behavioural Disorder</td>
<td>71% of children with emotional and behavioural disorders have clinically significant language deficits (Brenner et al 2002).</td>
<td>USA</td>
<td></td>
</tr>
<tr>
<td>ADHD</td>
<td>ADHD affects 5% of school-aged children (5% of school-aged children in the UK equals 500,000 children), while 1% of school-aged children meet the diagnostic criteria for severe-combined type ADHD (NICE 2000). 2/3 of children with ADHD (65%) continue to experience symptoms into adulthood.</td>
<td>UK</td>
<td>Male to female ratio 4:1.5 (SIGN 2001)</td>
</tr>
<tr>
<td>Selective Mutism</td>
<td>Selective Mutism: between 2 and 18 children per 10,000 (Johnson &amp; Wintgens 2001) 0.69% aged 4-5 yrs on school entry, falling to 0.03% after 8 months (Brown and Lloyd 1975). 0.08% aged 7yrs (Kolvin &amp; Fundudis 1980.)</td>
<td>UK</td>
<td></td>
</tr>
<tr>
<td>Bi-polar disorder</td>
<td>Bi-polar disorder: 1/100 (<a href="http://www.nhs.uk/conditions/Bipolar-disorder/">http://www.nhs.uk/conditions/Bipolar-disorder/</a> 2010)</td>
<td>UK</td>
<td></td>
</tr>
<tr>
<td>Schizophrenia 1-year incidence 11.1/ 100 000 (Goldner et al 2002)</td>
<td>1-year - 0.34/100 (Goldner et al 2002) Lifetime prevalence 0.55/100 (Goldner et al 2002) 1/100 - 65% with fluctuating problems 10-15% experiencing severe long-term incapacity 1/5 recover within 5 years of 1st episode. 3/5 recover but still have symptoms that at times deteriorate. 1/5 continue to have symptoms. (Royal College of Psychiatrists 2009) Estimate of co-morbidity of Dysphagia and Schizophrenia is 23% &amp; 27% (Regan,</td>
<td>UK</td>
<td></td>
</tr>
</tbody>
</table>
### 4. What causes Mental Health problems?

Factors affecting MH can include both internal and external influences. MH can be associated with genetic, medical (including factors related to diet and nutrition, physical health, and pharmacology) and associated environmental factors or social and personal factors, related to the environment, quality of life, past experiences, education, and religious beliefs which may affect mental well-being and result in psychological problems. These internal and external influences produce differing consequences for the individual and their families and carers.

Communication disorders associated with MH problems include disorders of speech, language (particularly pragmatic abilities) voice, fluency, as well as selective mutism, and language-based learning disabilities (RCSLT Clinical Guidelines 2006, Speech Pathology Australia 2008). In addition, language difficulties and dysphagia can be present secondary to a mental health diagnosis, brought about by the side effects of some medications (Ruschena et al 2003). There are also specific MH disorders which have communication problems as part of the specific disorder, for example, Autism/Asperger’s syndrome, Selective mutism and Schizophrenia (Fine 2005). There are also MH disorders where language problems are not recognised and may be masked by the MH symptoms.

### 5. How does a co-morbidity of mental health and communication/eating/swallowing difficulties impact on individuals?

A high proportion of children, adolescents and adults presenting to mental health services with emotional and behavioural difficulties may have disturbances of speech, language, communication and some may have eating/swallowing difficulties. These difficulties may be intrinsic to the mental health problem, as in schizophrenia or may pre-date the mental health problem, as in language delay/disorder or dysfluency, or they may arise from it, as in drug-induced motor speech problems/swallowing problems or emotional behavioural problems.

Difficulties with social communication result in reduced access to education, recreation, employment, and social integration including forming relationships and expressing personality (Law et al 2009). Speech and language is critical in the diagnosis and monitoring of people with mental health problems (Fine 2005).

**Children and Adolescent Mental Health Disorders**

**Specific Speech, Language and Communication Needs (SLCN)**
Children with delayed or disordered speech and language are at risk of developing mental health problems. The ability to communicate and understand is essential to developing relationships and more general psychosocial development. Difficulties in communicating can lead to anxiety,
depression and behavioural problems that can affect the child's overall functioning and lifelong development. Law et al (2009) reported that the presence of early language learning difficulties were linked to mental health, literacy and subsequent employment outcomes. Law et al identified that a receptive language difficulty at 5 years was associated with a higher risk of mental health problems in adult life. Clegg et al (2005) also identified an increased risk of psychiatric disorders in adult life related to long term receptive developmental language disorders, e.g. theory of mind, verbal short-term memory, phonological processing difficulties, in association with significant difficulties in social adaptation. Children with an attention deficit, such as ADHD, in association with language impairment are at risk of developing social and emotional disorders (Snowling et al 2006). Those children who have problems with interpreting meaning, receptive language or pragmatic difficulties, find it harder to make sense of the outside world. Fine (2005) identified three major categories of meaning which may be compromised in psychiatric disorders, specifically, experience of the external world, the relationship to the listener and fitting the language into context. The evidence from studies show a higher rate of co-morbidity of speech and language impairments associated with psychiatric disorders (Beitchman et al 2001, Cantwell & Baker, 1991) and communication problems in certain psychiatric disorders (Snowling et al 2006).

Emotional & Behavioural Difficulties

Emotional & Behavioural Difficulties (EBD) is a collective term used for a range of symptoms which include behavioural, emotional and social difficulties (BESD) and social, emotional and behavioural difficulties (SEBD) which affect predominantly affect children. EBD and SEBD affect a child’s ability to adjust to school and social situations. Behaviours are serious enough to demand attention, have a specific pattern of occurrence and duration and interfere with the individual’s ability to complete desired activity or goals (Culliman 2004). The child may demonstrate a number of behaviours; an inability to learn that is unexplained, inability to build relationships, inappropriate behaviour or feelings, pervasive mood of unhappiness, physical symptoms or fears related to personal or school problems (Culliman 2004). There is a high prevalence of language disorders among children who present with EBD. Studies have identified a relationship between emotional and behavioural disorders and language disorders with a high incidence of co-morbidity particularly in semantic and pragmatic language skills (Silver 2000, Rinaldi 2003, Hyter 2001, Mackie & Law 2009, Nelson 2005, Brenner 2002). This co-morbidity tends to increase over time, Cantwell and Baker (1987) reported 54 % < 64% at 5 years. Brenner et al (2002) reported that an average of 71% of children with EBD had clinically significant language deficits of which 71% were pragmatic deficits, 64% were expressive deficits, and 56% were receptive deficits. There is a complex relationship between language and behaviour, language being the means of understanding a situation and of expressing wants, needs, ideas and controlling and maintaining social interactions. Children with EBD are at risk of academic failure, anti-social behaviour and may fail to reach their potential.

Attention Deficit Hyperactivity Disorder

Attention Deficit Hyperactivity Disorder is the most common childhood-onset behavioural disorder with symptoms of inattention, and/or impulsiveness and hyperactivity. ADHD usually starts at about 18 months, but might not be diagnosed until later, even until adulthood. Symptoms usually develop between the ages of three and seven, with boys more likely to be affected than girls. There are three main types of attention deficit disorder: Inattentive; Hyperactive-impulsive; and Combined Type (DSM-IV). Symptoms present in two or more different settings resulting in impaired functioning, resulting in difficulty in school or social situations. The cause of ADHD is still under investigation (Sonuga-Barke 2008). While intellect may be normal or advanced, more than half of children with ADHD have specific learning difficulties, such as dyslexia. It is estimated that 35% of children with ADHD also have learning difficulties. Children may have difficulties with language and executive functions which include pragmatic understanding, social cognition skills and meta-cognitive skills (Hyter 2003, Hyter et al 2001). They can have a lack of engagement yet, though learned strategies, can appear to be participating and fitting in with programmes (Stringer 2006). These difficulties impact on their ability to access verbally mediated interventions and benefit from standard therapy programmes. ADHD has a high co-morbidity with other developmental and psychiatric disorders. Taylor (2006) reported a co-
occurrence rate of 60% oppositional defiant disorder, 20% anxiety disorder, 30% learning disorder and developmental coordination disorder.

Coping with the symptoms can mean underachievement and poor self-esteem. Children with ADHD are also more likely to be depressed, anxious and obsessive, and may have some problems with speech, language and coordination. Hyperactivity may improve at puberty but the problems usually persist in some form throughout adult life, up to 60% of children show ADHD behaviour in adulthood.

Table 2: ADHD signs and symptoms (DSM-IV)

| Inattentive ADHD | • Fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.  
| • Has difficulty sustaining attention in tasks or play activities.  
| • Does not seem to listen when spoken to directly.  
| • Does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace.  
| • Has difficulty organizing tasks and activities.  
| • Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort, such as schoolwork or homework.  
| • Loses things necessary for tasks or activities, such as toys, school assignments, pencils, books or tools.  
| • Is easily distracted by extraneous stimuli.  
| • Is forgetful in daily activities. |

| Hyperactive-impulsive ADHD | • Fidgets with hands or feet or squirms in seat.  
| • Leaves seat in classroom or in other situations in which remaining seated is expected.  
| • Runs about or climbs excessively in situations in which it is inappropriate.  
| • Has difficulty playing or engaging in leisure activities quietly.  
| • Is often 'on the go' or often acts as if 'driven by a motor'.  
| • Often talks excessively.  
| • Blurs out answers before questions have been completed.  
| • Has difficulty waiting for own turn.  
| • Interrupts or intrudes on others. |

| Combined ADHD | • As above inattentive & hyperactive-impulsive ADHD. |

| ADHD not otherwise specified | • Meets some of the criteria for the above, but does not exhibit enough of the symptoms for a full diagnosis. |

*Autism or Autism Spectrum Disorders (ASD)* is a development disorder which limits the individual’s ability to use language and to relate socially and emotionally to other people. There is an association between autism and mental health problems. ASD affects the way an individual understands their world, communicates with, and relates to people around them. Whilst individuals with ASD can have all levels of cognitive and intellectual ability, there is a significant learning disability in some three-quarters of cases of ASD (WHO ICH 10). An individual can have differing levels of difficulty in social interaction, communication and imagination. Heightened sensitivity to sounds, textures, foods, light affects the ability interact in social settings and impacts on all aspects of everyday life and ability to remain or to work in certain environments. Individuals on the autism spectrum, especially the severe end, are at increased risk of co-morbid MH disorders and having MH issues (see Autism synthesis).
Learning Difficulties a developmental disorder which affects intellectual abilities impacting on cognition and physical abilities, limiting the individual's abilities to learn and to develop and use speech, language and communicate appropriately with others. There is an association between learning difficulties and mental health problems (Rojahn & Meier 2009). Learning Difficulties can impact on all areas of an individual's life and presents challenges for them throughout their life. Difficulties vary with the severity of the intellectual and physiological abilities present, and include difficulty in learning, understanding and communicating. Communication problems encompass expressive/receptive language, reading and writing, coordination, attention, memory, articulation, speech intelligibility, pragmatic understanding. Communication difficulties are associated with increased prevalence of challenging behaviour. Swallowing disorders may be present and are associated with increased ill health, chest infections and reduced survival. Difficulties with social communication are a predominant feature in reducing access to education, employment and social integration. Individuals with learning difficulties are at increased risk of co-morbid mental health disorders and MH issues as there can be lifelong complex needs (DoH 2005. 2002, The Foundation for People with Learning Disabilities 2002). (See Learning Disability synthesis).

Selective mutism is a childhood anxiety disorder (Sharp et al 2007, Johnson & Wintgens 2001), SM frequently co-occurs with a social phobia and has a high co-morbidity with developmental delays and delays in speech and language development and psychiatric disorders (Kristensen 2000, 2002). Prevalence is higher in ethnic minority populations and where there has been migration and bilingualism (Johnson & Wintgens 2001). Behaviours observed include nervousness, uneasiness, social awkwardness and a failure to speak in certain social environments as a result of social phobia. SM is primarily associated with childhood where the child does not speak in at least one social setting but is able to speak and speaks in other situations (DSM IV 2000). SM may be diagnosed when a child starts school, when the mutism interferes with educational and occupational achievement. A diagnosis of SM is made if the onset of non-speaking behaviour lasts at least one month and this failure to speak is not due to a lack of knowledge of the spoken language required in the social situation nor as a result of a speech, language or communication disorder, or a pervasive developmental disorder (PPD), schizophrenia, or other psychotic disorder. Children with SM may exhibit excessive shyness, fear of social embarrassment, social isolation, seriousness, withdrawal, stubbornness or aggression (ASHA 2009, Johnson & Wintgens 2001, Black & Uhde 1995). The individual may have a greater well-being when silent and so avoids speaking in situations which they find stressful. It most frequently occurs in early childhood when interaction begins outside the immediate family circle and can last a few months or can continue into adulthood. In a study by Remschmidt et al (2001), 60% of the adults studied still had symptoms of SM with lack of self-confidence, independence, achievement, and social communication skills.

Eating/Swallowing difficulties may form part of a structural, sensory or physiological problems, learned behaviour, or as a side-effect of certain drugs given for MH which can result in motor speech disorders or loss of saliva. Eating disorder not otherwise specified (EDNOS) involves disordered eating patterns. EDNOS is described in the DSM-IV-TR as a type of eating disorder that does not meet the criteria for any specific eating disorder, though it may meet some, but not all, of the diagnostic criteria for anorexia nervosa or bulimia nervosa. Anorexia nervosa and Bulimia are part of a serious psychological illness. Diagnosis (WHO ICD-10) is based on the presence of abnormal feeding habits and an associated body weight of 15% below normal range or a Body Mass Index of 17.5 or less. There are two types of anorexia: the restricting type and the binge eating / purging type. Physiological, psychological and social factors are thought to contribute to the onset of eating disorders. Controlling food intake through overeating or under eating may be used as a coping mechanism for feelings such as stress, anxiety, depression, sadness, anger or other difficult emotions. It is also associated with distortion/ negative body image and low self-esteem. Abuse may be associated with eating disorders (Something Fishy 2010). Eating disorders in childhood can impact upon the child’s ability to take enough nutrition to develop a growing mind and body and may lead to serious health problems, anaemia, dehydration, loss of periods, heart problems, kidney failure, malnutrition and even death. Also, in EDNOS and bulimia, stomach acid from repeated vomiting can lead to the erosion of tooth.
enamel. The associated psychological distress impacts both the child and family members and be a cause of great distress.

**Adult Mental Health Disorders**

*Psychosis* is an abnormal condition of the mind which involves a mental state where there is a disassociation with reality. There are four main symptoms associated with a psychotic episode: hallucinations, delusions, confused and disturbed thoughts, and a lack of insight and self-awareness. Functional causes of psychosis include: brain tumours, brain damage, focal epileptic disorders, schizophrenia, schizophreniform disorder, schizoaffective disorder, brief psychotic disorder, bipolar disorder, severe clinical depression, drug abuse, severe psychosocial stress, sleep deprivation, exposure to some traumatic event, abrupt or over-rapid withdrawal from certain recreational or prescribed drugs. Psychosis arising from organic conditions (neurological and electrolyte disorders) are termed ‘secondary psychosis’.

*Bipolar Disorder* is characterised by mood swings, ranging from mania seen in extreme happiness and depression seen in extreme sadness. Episodes can for long periods of time (months). Depression includes sadness, hopeless, lack of energy, difficulty concentrating and remembering things, a loss of interest in everyday activities, feelings of emptiness or worthlessness, feelings of guilt and despair, feeling pessimistic about everything, self-doubt, being delusional, having hallucinations, and disturbed, or illogical thinking, lack of appetite, difficulty sleeping and waking up early, and suicidal thoughts. Stresses include physical, sexual, or emotional abuse, relationship breakdowns, death of a family member or close friend. Mania usually follows periods of depression and includes, feeling very happy, talking very quickly, feeling full of energy, feeling full of self-importance, feeling full of new ideas and plans, being easily distracted, being easily irritated or agitated, being delusional, having hallucinations, and disturbed, or illogical thinking, not sleeping, not eating, and doing pleasurable things which often have disastrous consequences.

*Schizophrenia* is a psychological dysfunction where the individual has an altered view of reality, paranoia, delusions, disembodied voices, an inability to integrate thoughts and feelings coherently and with disrupted communication. Schizophrenia affects thoughts, feelings, language and behaviour (Royal College of Psychiatrists 2009, Crow 2008, 2004). The development of theory of mind and understanding of social interaction (Frith 2004, Frith & Frith 2010), understanding and effective communication can be disrupted and impact on communication in Schizophrenia. The pragmatic aspects of language may be disrupted so the individual may say very little, rarely initiate a conversation and speech may be illogical or lack meaningful discourse (Walsh 2008, Royal College of Psychiatrists 2009, Fine 2005). The characteristic symptoms include two or more symptoms; delusions, hallucinations, disorganized speech, lack or decline in speech, disorganized behaviour or catatonic behaviour, blunted affect, or lack or decline in motivation. Speech may include neologism, stock words and phrases, and incoherent discourse. A study by Regan et al (2006) found an increased incidence of dysphagia in schizophrenic patients of 32% compared to 6% in the general population. This may be related to high levels of dopamine and dopamine blockages that were found to be present in schizophrenia and which can affect swallowing abilities (Lynette Carl 2007). In addition, the side-effects of some medication can result in a dry mouth which may cause difficulty in speaking or swallowing. Also, the use of drugs (ecstasy, LSD, amphetamines, crack, cannabis) can precipitate schizophrenia, especially if such drugs are combined with alcohol. Other influencing factors may be related to social and personal factors and include stress, family tensions, childhood deprivation and abuse. Children over the age of five can develop schizophrenia but it is very rare before adolescence, the peak ages of onset are 20–28 years for males and 26–32 years for females. Swallowing problems may co-exist along with communication problems (Walsh et al. 2007).

*Dementia* is progressive disorder resulting in a global decline in intellectual abilities with a loss of brain function which includes deterioration both mental and motor functions, such as memory,
language, orientation and judgement and eating and swallowing ability. There is characterised by a progressive widespread loss of function which includes deterioration in mental functions, such as memory, language, orientation and judgement. The symptoms of dementia include loss of memory, confusion and problems with speech and understanding, sensation and praxis (dexterity/motor skills) and feeding and swallowing difficulties (dysphagia). The individual may develop confusion, restlessness, irritability, tearfulness, be agitated, use repetitive behaviours, be aggressive, inappropriate sexual behaviour and incontinence which distress those around them (Mental Health Foundation 2010) (See Dementia synthesis).

Eating/Swallowing difficulties can develop at any age but frequently develop during adolescence and early adulthood related to medical or biological factors, social, environment, and/or the family dysfunction. ED can result in very low self-esteem, distorted body image, anxiety, depression and can lead to a risk of suicide, substance abuse or self-harm. Psychological and physical symptoms include poor sleeping patterns, concentration problems, focus on food or calories, lack of interest in others, food and eating obsession. Physical symptoms include stomach shrinking, fatigue, weakness, feeling cold, slowed metabolism, constipation, brittle bones, fertility problems, liver damage. Vomiting may result in a loss of tooth enamel. A learning difficulty, autism or other developmental problems can affect eating ability or desire for foods, for example, in autism there may be an aversion to specific colours or textures of foods with a refuse to eat them (College of Psychiatrists accessed March 2010) (See dysphagia synthesis).

The impairments, activity restrictions, psychosocial and wellbeing consequences that are frequently found in those with communication and swallowing disorders associated with MH are listed in Table 3.

**Table 3: International Classification of Functioning (ICF) dimension and Mental Health**

<table>
<thead>
<tr>
<th>ICF dimension</th>
<th>Impact</th>
</tr>
</thead>
</table>
| Impairment    | Language  
|               | Attention  
|               | Memory  
|               | Executive functions  
|               | Psychosis  
|               | Personality disorder  
|               | Incidence or patterns of verbal or physical anger/aggression  
|               | Anxiety  
|               | Depression  
|               | Addiction  
|               | Attachment  
|               | Thought disorder  
|               | Swallow  
|               | Sensation  
|               | Mood  
| Activity      | Effort and fatigue in communicating  
|               | Communication avoidance  
|               | Ability to use language meaningfully  
|               | Development of inappropriate behaviours  
|               | Dependency on others for communication  
|               | Lack of engagement  
|               | Incoherent utterances, ‘voices’  
|               | Challenging behaviour  
|               | Fidgeting/squirming  
|               | Eating  
| Participation | Loss of autonomy  
|               | Reduced independence  
|               | Restricted environment  
|               | Problems coping in social situations  

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### 6. What are the aims/objectives of Speech and Language Therapy interventions?

Language is integral to the diagnosis and treatment of many psychiatric disorders. While reduced communication skills can affect self-esteem, self-identity, relationships, educational attainment and work attainment. The ‘communication difficulty’ is commonly cited as the most challenging aspect of mental illness (Stephenson & Smith 2008).

SLTs aim to provide a detailed assessment of the individual’s communication and swallowing difficulties and needs, and aim to contribute to facilitating appropriate diagnosis. SLTs can also provide recommendations to facilitate communication, a programme of intervention and training to family, carers and professional staff. SLTs aim to work across agencies (New Horizons 2009) and will aim to identify gaps in speech and language therapy provision, and provide carry-over of therapy interventions.

A wide range of interventions commonly focusing on specific behaviours of the individual child have been developed. Law and Plunkett (2009) have grouped interventions described in research as being didactic (which commonly focus on specific behaviours using behavioural modification techniques such as modelling and reinforcements) hybrid which usually have didactic components but place an emphasis on naturalistic context and pharmacological.

SLT services aim to provide a service across 3 areas:
- Children and Adolescent Mental Health Disorders
- Adult Mental Health Disorders excluding Dementia
- Progressive Mental Health Disorders: Dementia*
  *note: a separate synthesis is available on dementia

SLT involvement can be direct or indirect care.

- **Direct care** will incorporate assessment, advice, care plans, intervention incorporating the development of appropriate materials for augmentative/alternative communication where required.
- **Indirect care** incorporates risk assessment, preventative consideration, education and training, and liaison with the multidisciplinary teams and family and carers. Work will involve representing people with communication difficulties and mental health problems in different settings, making programmes accessible.

SLT will aim to:-

- assess communication and swallowing ability.
• provide advice, programmes and training to individuals and their carers to facilitate effective communication and safe swallowing.
• advise on the most effective means of presenting information and choices.
• advise on the most effective way to engage the user in verbally mediated interventions and to minimise the effects of the communication disorder where possible.
• advise on the most effective means of interaction with the individual where spoken language has limited meaning, to improve quality of life/minimise distress for the individual and carer.
• ascertain and facilitate expression of wishes and feelings in the individual.
• identify communication ability and capability to use alternate communication through aids and adaptations.
• provide advice, training, support to use communication aids and adaptations to individual and carers.
• provide advice, training, support around modification of the environment to facilitate participation of individuals with a communication disorder.
• increase exposure to verbal communication and reduce anxiety to communication. See Table 4.
• support determination of mental capacity.
• act as an advocate for the individual with communication difficulty.

Table 4: International Classification of Functioning (ICF) dimension: SLT Aims of intervention

<table>
<thead>
<tr>
<th>ICF dimension</th>
<th>Techniques to improve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impairment</td>
<td>Language skills</td>
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<tr>
<td></td>
<td>Cognitive skills</td>
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<td></td>
<td>Sensory skills</td>
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<td></td>
<td>Speech skills</td>
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<tr>
<td></td>
<td>Motor control of feeding musculature</td>
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<tr>
<td>Activity</td>
<td>Ability to understand and express</td>
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<td>Ability to communicate</td>
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<td></td>
<td>Ability to take turns</td>
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<td>Ability to provide a narrative</td>
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<td>Ability to negotiate</td>
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<td>Ability to shape behaviour, appropriate to social setting</td>
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<td></td>
<td>Ability to eat safely</td>
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<td></td>
<td>Ability to use augmentative communication</td>
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<td></td>
<td>Ability to enjoy talking in different settings</td>
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<td></td>
<td>Ability to control behaviour</td>
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<td></td>
<td>Ability to engage</td>
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<tr>
<td>Participation</td>
<td>Social integration – reduce social isolation</td>
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<tr>
<td></td>
<td>Social participation - develop ability to behave appropriately in social settings, interact and participate with peers</td>
</tr>
<tr>
<td></td>
<td>Control of challenging behaviour</td>
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<tr>
<td></td>
<td>Self-esteem as a communicator</td>
</tr>
<tr>
<td>Well-being</td>
<td>Advise on strategies to reduce anxiety, frustration and upset</td>
</tr>
<tr>
<td></td>
<td>Advise on situational awareness to reduce stressors</td>
</tr>
</tbody>
</table>

7. What is the SLT management in Mental Health?

SLTs management needs to be integrated as an integral part of the appropriate multidisciplinary team. This will be across agencies in most cases (Kramer, Bloch & Parker 2008, Scofield et al 2009) and encompass behavioural, educational, work and social issues. When involved, the Speech and Language Therapy Service will liaise with the family and appropriate staff and carers. Management will involve:
• initial observation and fact finding, working with client, carer, professional staff, such as school staff.
• giving advice and training, contributing to decisions and advising on appropriate interventions, collaborative problem solving.
• providing assessment to highlight any other speech, language, feeding or swallowing difficulties.
• providing appropriate communication support resources.
• advising on relevant aspects of communication and swallowing in health promotion to at risk groups, prevention and rehabilitation programmes.
• facilitating shared working with a variety of user organisations.
• differentiate programmes to meet individual’s needs.

SLTs are uniquely placed to assess communication in individuals with MH and to provide education, training and support (Enderby & Emerson 1996). SLTs provide services to individuals with MH where the main difficulty is a speech, language and communication problem. The level of involvement varies with the individual’s specific MH problem and the presenting speech, language and communication behaviours (Clegg et al 2007).

SLTs will want to involve service users and their family and carers in planning and delivery of care and to promote the safety of individuals and carers, staff and general public. Maximising communication and ensuring safe feeding helps to improve mental health and well-being. SLTs are an integral member of the team and assist in developing the care programme and undertaking risk assessment.

Table 5: SLT as a member of different teams may include the following

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Teams</th>
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</thead>
<tbody>
<tr>
<td>0 - 2 years</td>
<td>Family/carers, Health Visitor and Health Team and the specialist Child and Adolescent Mental Health Services (CAMHs) team who include child psychology, child psychiatry, clinical psychology, paediatrician, occupational &amp; physical therapy, audiology, Social Services team, voluntary and independent sectors.</td>
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<tr>
<td>3 – 4 years</td>
<td>Family/carers, Nursery Staff, Health Team and Child and Adolescent Mental Health Services and the Education Team (includes teachers, educational psychologist, specialist teachers), Social Services team, voluntary and independent sectors.</td>
</tr>
<tr>
<td>5 and 18 years</td>
<td>Family/carers, Education Team, Health Team and specialist Child and Adolescent Mental Health Services, Social Services team, local authority, voluntary and independent sectors, Youth offending Teams.</td>
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<tr>
<td>19 year upwards</td>
<td>Family &amp; carers Holistic care involves a wide range of statutory organisations, specialist support services within organisations and social groups such as –</td>
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<td></td>
<td>Parenting supports</td>
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<td></td>
<td>Higher Education providers</td>
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<td></td>
<td>Joint Learning Disability/Mental Health Teams</td>
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<td></td>
<td>Psychiatric Teams/Psychologists/ Mental Health Teams</td>
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<tr>
<td></td>
<td>Geriatricians &amp; Community support teams</td>
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<td></td>
<td>Specialist dedicated services</td>
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<td></td>
<td>Social Services teams</td>
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<td></td>
<td>Local Authority – e.g. specialist residential, education</td>
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<td></td>
<td>Specialist employment services</td>
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<td></td>
<td>Voluntary and independent sectors</td>
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<td></td>
<td>Police and probation services</td>
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<td></td>
<td>Criminal justice system</td>
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<tr>
<td></td>
<td>Forensic and secure services</td>
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<td>Employers and business/commerce</td>
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<td></td>
<td>Ethnic and faith groups</td>
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<td></td>
<td>Relationship guidance</td>
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</tbody>
</table>
Augmented and Alternative Communication

Augmentative and alternative communication systems are used with individuals to facilitate communication. Communication books or high tech (laptops, lightwriter, Blackberry) or low tech aids (Picture Exchange Communication system, Makaton, drawing) can facilitate communication and relieve the pressure to communicate in specific settings while allowing others to understand. AAC can aid communication, relieve frustration and help to reduce anxiety in social situations. SLTs can advise on AAC usage as a component of the interventions offered.

Cultural diversity

Individuals who use English as their second language and have a mental health problem, along with their families may need help to access services. An interpreter may be required to assist with conducting the SLT assessment to ensure it is both accurate and reliable and to facilitate understanding of therapy and implementation of treatment strategies. There are time and cost implications when working with interpreters/co-workers for example, in taking a case history, completing a full assessment in all languages spoken by the individual and their family. SLTs working with people with mental health problems need to be aware of cultural and religious factors which may impact on ability to access services, e.g. timings of services need to be culturally sensitive, for example, not offering appointment times which coincide with religious observations (Communicating Quality 3 2006).

8. What is the evidence for SLT interventions?

Note: The Syntheses within this RCSLT series has separate sections on Autism, Dementia and Learning Disabilities and reports on specific Mental Health issues secondary to those of other communication disorders. This particular section addresses mental health issues associated with schizophrenia, mutism, depression and psychoses.

Details of studies

Fourteen studies were considered in the assessment of SLT interventions for mental health. The scope of these studies reflects the paucity of evidence in this area with all studies stressing the need for further research. A defining characteristic and explicit aim of all papers was to demonstrate the potential contribution of SLT in managing and treating mental health problems. This was in terms of managing speech and language problems per se but also in terms of managing communication problems in order to facilitate psychosocial therapeutic interventions. This is a particularly important consideration in a therapeutic area reliant on successful communication between patient and practitioner.

Four of the studies were not intervention studies. One paper (McInnes 2005) was an expert commentary calling for more cross-disciplinary research, including SLT, with children with selective mutism (SM). Three studies (Doré 2009, Gray 2002, Walsh 2007) were observational studies aimed at identifying communication problems and speech and language disorders associated with mental illness. All four studies discussed the contribution of SLT in the treatment of mental health problems. Given the lack of evidence in this area they are referenced here for information. However they are not considered in more detail as they do not evaluate the effectiveness of therapeutic interventions.

Of the remaining ten studies all ten were published in English with the earliest being published in 1995. Five were conducted in the United States (USA), four in the United Kingdom (UK) and one in Canada. Three, one of which was a meta-analytic systematic review, included adults with schizophrenia. One study looked at children at risk of developing behaviour problems and five, one of which was a systematic review, included children with SM. A further systematic review considered the relationship between speech, language and communication difficulties and emotional and behavioural difficulties including attention deficit hyperactivity disorder. Within the
primary studies the ages of adults with schizophrenia were 35, 40 and 53 years. As far as it is possible to tell from the reporting, the age of children in the primary studies ranged from 4 to 13 years.

Study quality

Overall study quality was poor. Three systematic reviews constituted the best evidence. Whilst the review methods were of high quality the evidence available for inclusion within each review was not of high quality. The first of review (Mojtabai, 1998) [ref id 1053] included comparative studies of psychosocial treatments for schizophrenia. Methodologically the review was rigorous and the impact of the quality of the included studies was examined. However the characteristics of individual interventions and design of included studies were not reported in detail and it is not clear that any of the interventions assessed were classed at SLT. The second systematic review was a best evidence synthesis of treatments for SM. The majority of best evidence identified was in the form of case studies. As a result the review is not able to provide much in the way of effectiveness evidence. In addition it provides very little information on interventions that were classed as SLT. However the review was of high methodological quality and as such provides an excellent critical summary of the evidence base relating to SM. The evidence included in the third systematic review was also of poor quality make it difficult to generalise results.

It is not clear, from the reporting, whether any of the remaining seven studies were included in the above reviews. Of these seven studies, five were case studies that included a maximum of two (non-comparative) subjects. Two were observational surveys of the effectiveness of various treatments. Neither of these included a direct comparison of the interventions considered. Both studies had small samples (seventeen and 33 children) and collected proxy, subjective data on the effectiveness of treatments as perceived by the parents of the children. There was little evidence related to speech and language therapy impact with ADHD and EBD, and studies were too small or of a preliminary nature to include in this synthesis. However, we are aware that there are useful descriptive studies describing the role of SLT in the management of these conditions as reviewed by Law and Plunkett 2009.

Speech and Language Interventions

The interventions assessed are difficult to define and classify consistently across the nine studies. In some studies interventions were grouped together as ‘speech therapy’ with no further details specified. (Manassis 2008, Schwartz 2006, Stone 2002) The five case studies provided more descriptive detail. Most case study interventions included characteristics associated with behavioural therapy including desensitization and social communication skills training. Interventions often involved, in addition to the therapist, other personnel involved in the care of the participants and the participants’ peer group. In four case studies the intervention was delivered by an SLT practitioner or SLT researcher. The background of the therapist in the fifth case study (Rye, 1999) is not clear. The behavioural and social skills therapy associated with SLT in the case studies is classed as being separate from speech therapy in other studies (Mojtabai 1998 Schwartz 2006, Stone 2002 This makes it difficult to make comparisons between SLT and other therapeutic approaches most of the approaches presented included common elements.

Further details of interventions are given in the summary of individual studies below. Studies of participants with schizophrenia are considered first followed by studies of children with selective mutism and social communication problems.

Schizophrenia

Three studies, including one systematic review and two case studies, considered interventions for adults with schizophrenia.
A meta-analytic systematic review of treatments for schizophrenia (Mojtabai 2002) focussed on studies of psychosocial treatments in combination with somatic treatment (medication or electroconvulsive therapy (ECT)) compared with somatic treatment alone. The review included 106 comparative studies comprising 172 comparisons, 103 of which addressed the focus of the review. The review concluded that combined treatment was more effective than somatic treatment alone. This included improvement in relapse rates and sustained improvement at 12 months follow up. The reviewers undertook extensive univariate and multivariate sensitivity analysis according to 35 different moderator variables. Results were sensitive to a number of variables, the most important being sample size, publication date, geographical location and allegiance of the authors. Results were not sensitive to modality of psychosocial treatment, with the exception of group therapy which had the smallest effect size, nor to orientation of treatment (e.g. verbal, behavioural and cognitive therapies). None of the interventions was described as SLT. However the brief descriptions of behavioural interventions included characteristics similar to interventions in the SLT case studies summarised below. Limitations of the study were discussed particularly the limitations of the meta-analytic approach in exploring within study variation. Recommendations for further research include understanding the impact on effectiveness of patient characteristics and evaluation of common elements of different therapeutic approaches.

The case study by Clegg (Clegg 2007) included a single male subject, an informal patient in an acute psychiatric ward. The study by Kramer (Kramer, 2001) presented two separate cases, both male inpatients in a special hospital. None of the patients was described as having speech or language disorders. The patient in the Clegg study was described as having ‘poverty of speech’ whilst the subjects in the Kramer study were described as having ‘different linguistic frameworks’ compared with people without a diagnosis of mental illness. The interventions presented in the case studies both comprised two phases. The Clegg intervention involved an eight stage process of desensitization to verbal communication. The second phase aimed to increase the patient’s language productivity and increase awareness of his social communication skills by engaging him in shared tasks and in factual conversations. The effectiveness of the intervention was assessed by five measures, including self-esteem, communication anxiety and mean length of utterance. Post-intervention assessment suggested improvements in four of the five measures compared with baseline. The first stage of the intervention in the Kramer study involved discourse comprehension tasks aimed at improving language reception. The second phase was aimed at increasing language production and involved discourse production tasks based on the everyday activities of the patients. Improvements were reported in both patients, although this result was based on only one discourse sample from each case.

Both case studies provide limited evidence of effectiveness. However, within the limitations of the study design the Clegg study was of a higher methodological quality in that it included repeated measures of effectiveness, including baseline and post-intervention measures and an in depth discussion of the factors, other than the intervention, that may have contributed to the improvements observed.

**Selective mutism and social communication problems in children**

Five studies, including one systematic review, two surveys and two case studies considered interventions for children with SM. One systematic review considered intervention studies for children with speech, language and communication or emotional and behavioural problems. A further case study reported an intervention for two children at risk of developing behavioural and social communication problems.

A best evidence synthesis systematically reviewed evidence of effectiveness of the major treatment approaches for selective mutism. (Stone, 2002) 114 studies, mainly case studies, included in the review were categorised according to therapeutic model as follows; behavioural, biological, family systems, psychodynamic and ‘other models’. This final category accounted for eight studies and included ‘speech therapy’. Only 23 studies had enough data with which to calculate effect sizes. All of these were categorised in the behavioural model with the exception
of two studies that considered combined treatment. The review therefore did not report on the effectiveness of any intervention categorized as ‘speech therapy’. Based on the analysis of the limited data available the review sought to address broad questions of effectiveness and concluded that treatment was more effective than no treatment, behaviourally-oriented treatment was more effective than no treatment and that there was insufficient evidence to detect differences in different behaviourally-oriented treatment models. Whilst reporting no results relating to speech therapy, the brief descriptions of behavioural interventions included characteristics similar to interventions in the SLT case studies summarised below. Regression analysis suggested that patient characteristics including family history, temperament, age at onset of SM and duration of SM were important variables impacting on the effectiveness of interventions.

Two small scale surveys (Manassis 2008, Schwartz 2006) elicited parents’ opinion on the effectiveness of a range of medical and non-medical treatments received by their children, all diagnosed as having SM. The study by Manassis also assessed effectiveness according to clinician rated global functioning. In the study by Manassis non-medical treatments in addition to medical treatments were perceived as providing no additional benefit compared with medical treatments alone. Within the non-medical treatments it was not possible to separate results relating specifically to speech therapy. In the study by Schwartz all treatments were perceived as being of benefit with medication perceived as being most effective and speech therapy perceived as providing the least benefit. The studies by Manassis and Schwartz constitute the poorest quality evidence included in this overview. Due to a number of methodological flaws across both studies, including lack of direct observation, lack of within study, prospective allocation of treatments, lack of prospective, direct comparisons between treatment options results should not be interpreted as evidence of effectiveness.

Two case studies (Rye 1999, Watson 1995) assessed school-based interventions for children, one male, one female respectively, with SM. The interventions in both case studies had similar elements. Both were two phase interventions comprising phases of desensitization and social speaking skills training. Both involved school staff, parents and the participants’ peer group. The therapist in one case study (Watson 1995) is described as a Speech and Language Therapist. The background of the therapist in the other case study (Rye 1999) is not clear. Both reported improvements resulting from the interventions. In the Rye case study improvements were measured at baseline and post-intervention according to several dimensions including self-reported anxiety, frequency of verbalisation, school attendance and involvement in extracurricular activities. Improvements in the Watson case study were based on the subjective interpretation of the author.

A systematic review by Law and Plunkett (2009) considered the relationship between speech, language and communication disorders and emotional and behavioural difficulties in children. The review identified 21 intervention studies describing a range of interventions. These included: (1) drug therapy (2), Picture Exchange Communication System (PECS) training (1), pivotal response training (2), peer interventions (4), behaviourally oriented treatment (2) function communication training (2), classroom wide intervention (1) and social stories (2) speech and language interventions (5). There were 11 didactic interventions (9 measuring speech/language outcomes and 10 measuring behaviour outcomes) and 8 hybrid interventions (6 measuring outcomes in speech/language outcomes and 8 measuring behaviour outcomes). All studies reported evidence of positive effects on both communication and behavioural outcomes. However, the authors of this review considered that the studies were small scale and of poor methodological quality and concluded that this made it difficult to generalise results.

A case study by Hyter (Hyter 2003) reports a classroom based intervention provided to two male children, aged 4, assessed as being at risk of developing emotional and behavioural disorders and social communication difficulties. The intervention required collaboration between an SLT therapist and classroom staff and involved the children’s peer group. It comprised several components including in-service training for classroom staff, planning meetings, direct observation (to identify communication goals and strategies to support language development)
and classroom-based interventions. These latter included self-talk and parallel talking strategies, modelling and scaffolding techniques and opportunities for role play. Effectiveness was measured according to the Denver Developmental Screening Test II which was taken pre- and post-intervention. Both participants improved to some degree on three of the six dimensions of Denver II.

Conclusion

The ten studies focus on interventions aimed at addressing communication problems as opposed to speech and language development disorders. Due to the limited availability of research other than case studies there is little evidence of effectiveness provided by these ten studies. The systematic reviews and the case studies highlight important priorities for future research in this area including the need for studies capable of demonstrating the impact on effectiveness of patient characteristics and the importance of understanding the effectiveness of common therapeutic elements or components irrespective of the underlying therapeutic approach or classification. This latter consideration is reflected in the inconsistent classification of speech and language therapy alongside other therapeutic approaches within these ten studies.

Table 6: Studies considered in the synthesis

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Study design</th>
<th>Subjects</th>
<th>Intervention</th>
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<tbody>
<tr>
<td>Clegg J (2007)</td>
<td>UK</td>
<td>Case study</td>
<td>Single subject Adult (53 years) male with schizophrenia. Speech poverty. No other speech and language disorder.</td>
<td>2 phase intervention using traditional and non-traditional SLT methods including desensitization and social communication awareness</td>
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<tr>
<td>Doré MC (2009)</td>
<td>Canada</td>
<td>Observational study</td>
<td>Sixteen subjects Adolescent (12-17 years), 8 female, 8 male with psychosis</td>
<td>No intervention</td>
</tr>
<tr>
<td>Gray RM (2002)</td>
<td>USA</td>
<td>Observational study / expert commentary</td>
<td>Two sets of dizygotic twins Children (6 and 9 years), female with selective mutism</td>
<td>No intervention (Observational description of neuropsychological profiles.)</td>
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<tr>
<td>Hyter YD (2003)</td>
<td>USA</td>
<td>Case study</td>
<td>Two subjects Children (4 years), male, at risk of developing social communication difficulties.</td>
<td>Collaborative, classroom based multi-component, prevention focused intervention including modelling and scaffolding techniques and role play opportunities.</td>
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</tbody>
</table>
| Kramer (2001)    | UK      | Case study                   | Two subjects Adult (35 and 40) | Therapy programme focusing on language reception then
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<th>Study</th>
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<td>(years) male with schizophrenia. language production, involving discourse</td>
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<td>comprehension and discourse production tasks based on participants’ daily</td>
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<td>activities.</td>
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<td>or emotional and behavioural difficulties in children.</td>
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<td></td>
<td></td>
<td>survey</td>
<td>Children (mean age 8.33 years), 12 female, 5 male with selective</td>
<td>Interventions received alone or in combination</td>
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<td></td>
<td></td>
<td></td>
<td>mutism</td>
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<tr>
<td>McInnes A (2005)</td>
<td>Canada</td>
<td>Expert commentary</td>
<td>N/A</td>
<td>No intervention</td>
</tr>
<tr>
<td>Mojtabai R (1998)</td>
<td>USA</td>
<td>Meta-analysis</td>
<td>Studies of patients with schizophrenia.</td>
<td>Psychosocial treatment in combination somatic treatment (medication or</td>
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<td>electroconvulsive therapy)</td>
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<tr>
<td>Rye MS (1999)</td>
<td>USA</td>
<td>Case study</td>
<td>Single subject</td>
<td>Systematic desensitization, consultation with school personnel, training in</td>
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<td>Child (13 years) male with selective mutism</td>
<td>social speaking skills</td>
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<tr>
<td>Schwartz RH (2006)</td>
<td>USA</td>
<td>Observational cross-sectional survey</td>
<td>Twenty-seven parents. Parents of 33 children (mean age 7.9 years) with</td>
<td>Medication, speech therapy, behaviour modification therapy or counselling</td>
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<td>selective mutism</td>
<td>alone or in combination</td>
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<tr>
<td>Stone BP (2002)</td>
<td>USA</td>
<td>Systematic review</td>
<td>Studies of children with selective mutism</td>
<td>Psychotherapy, family systems therapy, behaviour therapy, pharmacological</td>
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<td>therapy, ‘other’ therapy</td>
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<tr>
<td>Walsh I (2007)</td>
<td>Ireland</td>
<td>Survey</td>
<td>Sixty subjects</td>
<td>No intervention</td>
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<tr>
<td></td>
<td></td>
<td>(Cross sectional</td>
<td>Adult (mean age 44.5 years (SD 13.5)) 28 male, 32 female with a range of psychiatric disorders</td>
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<td>survey to assess</td>
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<td>communication</td>
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<td></td>
<td></td>
<td>and swallowing)</td>
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<tr>
<td>Watson S (1995)</td>
<td>UK</td>
<td>Case study</td>
<td>Single subject</td>
<td>Collaborative school based intervention including desensitization and social communication skills training</td>
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<td></td>
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<td>Child (10 years), female with selective mutism</td>
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